Ministry of Health
& Family Welfare
Government of India

Mission Indradhanush

Operational Guidelines

2016

Mission Indradhanush:

In PRAGATI, Hon'ble Prime Minister Shri Narendra Modi calls for aggressive action plan to cover all children for immunization in a specific time-frame

"Hon'ble Prime Minister, Shri Narendra Modi, has reviewed Mission Indradhanush under 'PRAGATI' – the ICT-based, multi-modal platform for Pro-Active Governance and Timely Implementation" with Chief Secretaries on 17 February 2016. During the session, he emphasized the need for an organized and aggressive action plan to cover all children for immunization in a specific time-frame.

Source:http://pmindia.gov.in/en/news_updates/pms-interaction-through pragati9/?comment=disable

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LIST OF ACRONYMS

AD	auto-disable
AEFI	adverse event following immunization
ANM	auxiliary nurse midwife
ASHA	accredited social health activist
AVD	alternate vaccine delivery
AWW	*Anganwadi* worker
BCC	behaviour change communication
BCG	*Bacillus Calmette-Guerin* vaccine
CBO	community based organization
CES	coverage evaluation survey
CHC	community health centre
CMO	chief medical officer
CSO	civil society organization
DHS	District Health Society
DIO	district immunization officer
DLHS	district level household and facility survey
DPT	diphtheria–pertussis–tetanus vaccine
DTFI	district task force for immunization
DUDA	district urban development agency
EPI	expanded programme on immunization
GoI	Government of India
HMIS	health management information system
HRA	high-risk area
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Services
IEC	information, education and communication
ILR	ice-lined refrigerator
IMA	Indian Medical Association
IPC	interpersonal communication
ITSU	Immunization Technical Support Unit
JE	Japanese Encephalitis
LHV	lady health visitor
MCH	maternal and child health

MCP	mother–child protection (card)
MCTS	mother and child tracking system
MCV-2	measles-containing vaccine second dose
MD (NHM)	Mission Director, National Health Mission
MI	Mission Indradhanush
MOIC	medical officer in-charge
MO	medical officer
MoHFW	Ministry of Health & Family Welfare
NCC	National Cadet Corps
NGO	nongovernment organization
NPSP	National Polio Surveillance Project
NSS	National Service Scheme
NTAGI	National Technical Advisory Group on Immunization
OPV	oral polio vaccine
OVP	open vial policy
PRI	*panchayati raj* institution
RCH	reproductive and child health
RI	routine immunization
RMNCH+A	reproductive, maternal, newborn, child health and adolescent health
RVV	rotavirus vaccine
SHG	self-help group
SHS	State Health Society
SIO	state immunization officer
SMO	surveillance medical officer
STFI	state task force for immunization
ToT	training of trainers
TT	tetanus toxoid
UIP	Universal Immunization Programme
UNICEF	United Nations Children's Fund
VPD	vaccine preventable disease
VVM	vaccine vial monitor
WHO	World Health Organization

BACKGROUND

India's immunization programme, launched in 1985, is one of the largest health programmes of its kind in the world, catering to a birth cohort of 2.7 crore (27 million) children annually. The programme provides vaccination against eight life-threatening diseases (diphtheria, whooping cough, *Haemophilus influenzae* type B (Hib) causing pneumonia and meningitis, tetanus, polio, tuberculosis, measles and hepatitis B) in the entire country. In addition, vaccination against Japanese Encephalitis (JE) is provided in the selected endemic districts/states of the country. Recently, rotavirus vaccine (RVV) has been introduced in the four selected states (Andhra Pradesh, Haryana, Himachal Pradesh and Odisha).

Mission Indradhanush: Identify, enlist, mobilize, vaccinate and track to achieve full immunization

In spite of all positive changes, there are ongoing challenges and shortcomings in the national immunization programme. Despite being operational for the past more than 30 years, only 65% of children in India receive all vaccines during their first year of life, thus contributing to continued high burden of morbidity and mortality in children from vaccine preventable diseases (VPDs).

Based on full immunization estimated from routine immunization monitoring and Mission Indradhanush data, it is estimated that annually, more than 70 lakh (7 million) children in the country do not receive all vaccines that are available under the UIP—the highest number compared with any other country in the world. This is majorly due to sub-optimal data recording and reporting, as well as the dire need to improve disease surveillance system. It is critical to identify the districts where focussed efforts, systematic immunization drive and additional resources will be required for reaching all children with all available life-saving vaccines.

The Ministry of Health and Family Welfare, Government of India (MoHFW-GoI) is committed to rapidly address the inequity in immunization coverage and consolidate the health systems strengthening efforts. To strengthen routine immunization planning and delivery mechanism, the MoHFW, GoI, launched its flagship programme "Mission Indradhanush" in December 2014 to achieve more than 90% full immunization coverage in the country. As part of this, the country has implemented two phases of Mission Indradhanush in 2015 through eight rounds in high focus districts. Based on risk prioritization, the country was categorized into high, medium and low focus districts. Phase I of Mission Indradhanush targeted 201 high-focus districts, with four rounds of activity between April and July 2015. Phase II targeted 352 districts (73 districts repeated from phase I), with four rounds of activity conducted between October 2015 and January 2016.

This equity-based programme builds on polio strategies, tools, techniques and manpower to focus specific attention on identified high-risk populations with traditionally low coverage, such as slum dwellers, nomadic populations and migrant families living in brick kilns and construction sites. The mission also targets the 400,000 high risk areas identified in the polio programme as well as other underserved areas with inadequate health services (vacant health sub-centres, etc.), migrant populations, recent measles/diphtheria outbreaks or high dropout rates.

Leveraging special strategies developed by the polio teams to access high risk, hard-to-reach and underserved communities, Mission Indradhanush brought in communities that previously had only been reached for polio vaccination but with limited access to routine immunization services. Microplanning for Mission Indradhanush focused on improving coverage and addressing equity issues in access to immunization.

Riding on the success and learnings from Mission Indradhanush in 2015 wherein more than 37 lakh children were fully immunized and about 37 lakh pregnant women were vaccinated, the GoI has decided to continue with this initiative. The main objective is to accelerate the momentum by planning to target 50% of estimated 70 lakh partially vaccinated or completely unvaccinated (missed) children in the next wave of Mission Indradhanush (Phase III) in 2016. The plan is to reach out to the 216 high focus districts across 27 states/union territories for achieving 90% coverage earlier than 2020.

RATIONALE FOR MISSION INDRADHANUSH

Evidence shows that unvaccinated and partially vaccinated children are most susceptible to childhood diseases and disability, and run a three to six times higher risk of death as compared with fully immunized children.

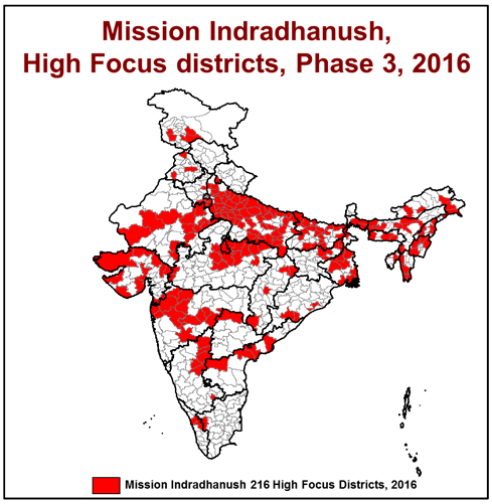
There are wide variations in the proportion of unvaccinated and partially vaccinated children within states and districts. Recent evaluations have indicated that the major reasons for inability to reach with all vaccines to children in the entire country are lack of awareness among parents about the benefits of vaccination, fear of adverse events following immunization (AEFI) and operational reasons such as non-availability of vaccines or vaccinators during vaccination sessions.

It is critical to identify the unvaccinated or partially vaccinated children and address programmatic issues with focussed microplanning, provision of additional financial resources and systematic immunization drives to reach these children with all available life-saving vaccines.

2.1 What is Mission Indradhanush?

The MoHFW, GoI, launched Mission Indradhanush in December 2014 as a special drive to vaccinate all unvaccinated and partially vaccinated children under UIP.

Figure 1. Phase III: High-focus districts, 2016



The Mission focuses on interventions to improve full immunization coverage for children in India from 65% in 2014 to at least 90% earlier than 2020, this will be done through special catch-up drives.

Under Mission Indradhanush, the government has identified 216 high focus districts across the country. The states of Uttar Pradesh (55 high focus districts) and Bihar (19 high focus districts) account for 38% and 10%, respectively, of the total missed children. The states of Maharashtra, Rajasthan, Gujarat, Madhya Pradesh and Assam, with a total of 61 high focus districts, account for 30% of the total missed children.

Figure 1 illustrates 216 high-focus districts identified by the government). Phase III of Mission Indradhanush will target 216 high-focus districts. (A list of 216 high-focus districts has been provided in Annexure 1).

OBJECTIVES OF MISSION INDRADHANUSH

The main objective of Mission Indradhanush is to ensure high coverage of children and pregnant women with all available vaccines throughout the country, with emphasis on the identified 216 high focus districts during phase III.

3.1 Specific objectives

With the launch of Mission Indradhanush, the government aims at:

- Generating a high demand for immunization services by addressing communication challenges;
- Enhancing political, administrative and financial commitment through advocacy with key stakeholders; and
- Ensuring that the unvaccinated and partially vaccinated children are fully immunized as per the national immunization schedule (Annexure 2).

3.2 Areas under focus for Mission Indradhanush Phase III

Mission Indradhanush will be a nationwide drive, with focus on 216 identified high focus districts. The key areas to be reached through Mission Indradhanush will be:

- Areas with vacant sub centres – no auxiliary nurse midwife (ANM) posted for more than 3 months.
- Villages/areas with three or more consecutive missed routine immunization sessions – ANMs on long leave or other similar reasons.
- High-risk areas (HRAs) identified by the polio eradication programme that are not having independent routine immunization sessions and clubbed with some other routine immunization sessions. These include populations living in areas such as:
    - urban slums with migration
    - nomadic sites
    - brick kilns
    - 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.).

- Areas with low routine immunization coverage identified through measles outbreaks, cases of diphtheria and neonatal tetanus in the last 2 years.

STRATEGY FOR MISSION INDRADHANUSH PHASE III

Mission Indradhanush will be a nationwide intensified routine immunization drive for ensuring high coverage throughout the country, and will be conducted in 216 high focus districts.

A total of four rounds will be conducted under each phase of Mission Indradhanush. Upon completion of each phase, districts must ensure that these sessions are included in regular routine immunization plans. Targeted beneficiaries will be pregnant women and children up to 2 years of age; however, children up to 5 years need to be focussed upon to improve booster dose coverage and if required school campaigns may be conducted.

- **The priority for conducting Mission Indradhanush sessions should be areas with weak routine immunization coverage in the district. This will require deployment of ANM to areas outside of her own sub-centre and block.**
- **All ANMs should be engaged for 7 working days over and above the regular routine immunization days excluding Sundays and holidays for conducting session during Mission Indradhanush. Sub centres having delivery facilities need to plan ANM deployment accordingly.**

4.1 Implementation of Mission Indradhanush

- Mission Indradhanush is a special immunization drive spread over 7 days. These 7 days do not include the routine immunization days planned in that week. Such routine immunization sessions should be held as already planned.
- All identified areas that require routine immunization strengthening but have no/infrequent routine immunization sessions must be reached through Mission Indradhanush sessions.
- Planning should be made in such a way that all ANMs in district are involved for 7 working days (in addition to routine immunization days) to visit and cover the areas for maximum immunization coverage.

- **Mission Indradhanush is a drive spread over 7 days.**
- **These 7 days do not include the routine immunization days planned in that week**
- **Ensure there is a 7 day plan (in addition to routine immunization days) for all ANMs in district.**

- The ANMs should be deployed to other sub-centre area within the same or adjoining blocks or urban areas in the same district. The planning for Mission Indradhanush sessions in district should be done in the following ways:
  - ANMs working in rural areas with less than 7 days of involvement in Mission Indradhanush in their own sub-centre areas should be deployed to low

performing/coverage areas or vacant sub centers in identified urban areas for Mission Indradhanush.

- To cover the unreached/vulnerable population groups with limited human resources 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 Mission Indradhanush sessions in these urban areas.

Every district should identify urban nodal officer(s) for planning and implementation of activities during Mission Indradhanush and routine immunization.

State and district task force to ensure compliance.

- Head count survey is a mandatory activity to be conducted through house to house visits before the first round of Mission Indradhanush. This head count survey will be conducted by ASHA/AWW/mobilizer for estimation of beneficiaries in the catchment area for each of the planned sessions for Mission Indradhanush.

- **Mission Indradhanush sessions should only be held after conducting and enlisting of beneficiaries through head count survey in the catchment area.**
- **Enlisting of beneficiaries through head count survey will ensure completeness of due lists and tracking of beneficiaries.**

- The head count survey will be utilized for preparation of name-based due lists for tracking and mobilization of beneficiaries (Targeted beneficiaries will be pregnant women and children up to 2 years of age; however, children up to 5 years need to be focussed upon to improve booster dose coverage).
- Due lists for subsequent Mission Indradhanush rounds will be updated using name-based immunization coverage recorded in Mission Indradhanush tally sheets during each round.
- Mission Indradhanush will be implemented according to a roster prepared following the planning process. This includes planning meetings at district and block levels, and oversight provided by district task force for immunization (DTFI).

COMPONENTS OF MISSION INDRADHANUSH

The two main components of Mission Indradhanush will be:

- Operational planning
- Communication planning

5.1 Operational planning

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

5.1.1 Fixed and outreach sessions

Medical officer in-charge (MOIC) for the block/urban planning unit will conduct a detailed planning for the additional sessions to be conducted in the planning unit. In addition, provision for vaccination should be made at health posts, primary health centres (PHCs) and district hospitals on all days of Mission Indradhanush.

- **Sites for vaccination**: Primary schools, *anganwadi* centres, private dispensaries, nongovernment organization (NGO) sites or any other locations that are easily accessible and acceptable to the community can be used as immunization sites. In addition, urban health posts, post-partum centres, family welfare centres and local influencers' premises may be utilized in urban areas.
- **Availability of human resources**: All ANMs in district will conduct Mission Indradhanush session for 7 working days in addition to routine immunization days. Other health staff trained for administering injection available from the same or neighbouring community health centre (CHC)/block/PHC/NGOs (LIONS, Rotary, etc.), retired health workers and staff available from other government agencies such as Medical colleges, ANM/nurse training school, Employee's State Insurance Corporation, Central Government Health Scheme, Armed Forces, Railways, District Urban Development Agency (DUDA)/State Urban Development Agency (SUDA) and community based organizations (CBOs) should be utilized to reach the largest number of children.

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

- **Timings***:* The activity will be conducted from 09:00 to 16:00. However, sessions should be planned based on availability of the targeted population to maximize the benefits.
- **Team***:* A team will comprise one vaccinator and two mobilizers, 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.

5.1.2 Mobile sessions

Mobile sessions should be planned at places where routine immunization coverage is weak and the small number of beneficiaries does not warrant an independent session. These places include peri-urban areas, scattered slums, brick kilns and construction sites. For these sessions, alternate means such as mobile vans should be planned in the format given at Annexure 11. It is important to ensure that the vials of *Bacillus Calmette-Guerin* (BCG), Measles, Rotavirus vaccine, and Japanese Encephalitis (JE) vaccines that are opened at one site are not used at the next site. The Integrated Child Development Services (ICDS) department & Rashtriya Bal Swasthya Karyakaram (RBSK) school health teams may support these mobile sessions through supplementary nutrition services that may be provided to beneficiaries in these hard-to-reach areas.

- **Include all immunization sessions held under Mission Indradhanush (that are not part of routine immunization microplan) into routine immunization microplans.**
- **The budgetary support for the same should be reflected in the district health action plan (DHAP) and subsequently in the state PIP.**

5.1.3 Planning considerations

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

- **Meticulous planning of immunization sessions at all levels**: It is important to plan sessions for identified areas where the reach of immunization programmes is inadequate. Ensure availability of sufficient vaccinators and all vaccines during routine immunization sessions.
- **Effective communication and social mobilization efforts**: Generate awareness and demand for immunization services through need-based communication and social mobilization activities (mass media, mid media, interpersonal communication, school and youth networks and corporates).
- **Intensive training of health officials and frontline workers**: Build capacity of health officials and workers for routine immunization activities to ensure the highest quality of immunization services delivery to beneficiaries.
- **Establish accountability framework through task forces**: Enhance involvement and accountability/ownership of state and district administrative and health officials through state and district task forces for immunization. It is important to use concurrent session monitoring data to plug gaps in implementation.

5.2 Communication planning

- To meet and sustain coverage goals under Mission Indradhanush, a well-carved strategic communication plan needs to be in place, reaching out to communities

residing in rural as well as urban areas, hard-to-reach populations and building trust in health-care services. This calls for identifying communication methods or channels that are the most appropriate for targeted stakeholders, that are liked and used by them and can most effectively reach them with programme messages. The communication plan also needs to take into consideration specific communication activities at different levels of operation.

- A need-based communication and social mobilization activities should be planned to achieve the following objectives:
  - Demand generation through increased visibility
  - Advocacy through media, professional bodies and political leadership
  - Capacity building of immunization workforce on communication
  - Social mobilization through interpersonal communication, school and youth networks and corporates
  - Concurrent monitoring of communication interventions.

5.2.1 National communication plan

Communication activities initiated at the national level will focus on mass media channels, their frequency and periodicity, news media outreach and social media activities. The communication activities will include:

- Launch of Mission Indradhanush Phase III
- National media outreach and management
- Airing of TV and Radio spots on national and regional channels
- Airing of Radio jingles on FM and AIR
- Newspaper advertisements (in leading English and Hindi dailies)
- SMS campaigns
- Social media engagement through Twitter, Facebook and YouTube
- Consolidated progress report on monitoring of communication interventions

5.2.2 State communication plan

Communication plan at the state level will include the following key components. Each component will have specific communication activities to reach out to a range of stakeholders with information and messages on various programme components.

- Demand generation
- Capacity building
- Coordination and convergence
- Advocacy and social mobilization
- Media engagement
- Communication monitoring

The communication plan will be rolled out through the following activities:

- Development of state communication action plan using the 360 degree communication approach where mass media, mid media and interpersonal communication (IPC) channels would be used.

- Capacity building
    - Training of state/district officials on operationalization of communication plan
    - Capacity-building of media spokespersons

- Advocacy with
    - Other Line departments (Panchayat department , Rural Development department , WCD department , Education, WASH)
    - Development partners
    - CBO and NGOs (MNGOs)
    - Religious institutions (Wakf board, Ramakrishna Mission, BSS, Diocesan Social Service Societies (DSSS), *Jamai-te-ulema*-e-Hind, State Haj Committees)
    - Local political leaders (member of parliament [MPs], member of legislative assembly [MLAs])
    - Professional bodies such as Indian Medical Association (IMA) and Indian Academy of Paediatrics (IAP)

- Mass media
    - Airing of TV and radio spots on regional channels
    - Radio jingles on local FM
    - Newspaper advertisements in state-level newspapers (English and Hindi)
    - SMS campaign

- Media engagement through
    - Media orientation
    - Press briefings
    - Media tracking and analysis

- Supportive supervision visits to poor performing districts by state officials

5.2.3. District communication plan

The plan details out suggested communication activities and also ways to reach out to specific populations and groups in high priority or geographically hard-to-reach areas. A few activities have been suggested for hilly/flood prone/desert/jungle/unrest areas/resistant or underserved pockets/urban slums/tribal areas and mobile/migrant populations. It is left to the discretion of the states to decide the kind of activities they find appropriate.

At the district level, dedicated communication plans will be made for the following areas:

- High-priority areas
- Resistant and underserved pockets
- Urban slums
- Tribal areas

- Migrant/mobile populations

This plan describes activities to be undertaken at the district level for components similar to the state plan. Communication activities at the district level will include the following:

- Development of district communication action plan using the 360 degree communication approach where mass media, mid media and interpersonal communication (IPC) channels would be used.
- Capacity building
  - Training of district health officials, line departments, e.g., education, PRI WASH and NGO partners on social mobilization and advocacy
  - Training of ANMs, ANM supervisors, LHVs, BEEs and community mobilizers , ASHA supervisors on IPC skills
  - Capacity-building of media spokespersons for crisis management in case of AEFIs
- Advocacy and Social Mobilization
  - Meetings with key influencers for social mobilization
    - Religious leaders
    - Ward members/councillors
    - Panchayati raj institutions (PRI)
    - Teachers
    - Local doctors, IAP/IMA members
    - Civil society organizations (CSOs), National Cadet Corps (NCC) and National Service Scheme (NSS)
    - Local political leaders (MPs, MLAs)
    - Institutionalize a reward and recognition system for well performing ANMs/ASHAs.
- District-level media management, including media orientation and press briefings (give out updates before and after each round), organize field visits to the media; take them to the areas where Mission Indradhanush is being organized).
- Mass media
  - Airing of TV spots on local channels and cable TV
  - Radio jingles on local FM channels
  - Newspaper advertisements in local regional dailies in local language
  - SMS campaign
  - Printing of IEC materials
- Develop implementation plan for IEC materials e.g. posters, pamphlets, flipbooks, hoardings, banners, flex boards and balloons.
- Monthly district-level planning and review meetings under chairmanship of DM/ DC with ICDS, PRI and allied departments for intersectoral convergence for coordination in implementation.
- Monthly and quarterly meetings of inter-agency communications group.
- Monitoring of communication activities.

The prototypes for all the communication activities under mass and mid media will be developed at the national level. The open files of the prototypes will be shared with the states and the states will further share the prototypes with the districts for translation, printing and dissemination. The states may also adapt the prototypes according to their local context.

The calculation for the printing of the IEC (information, education and communication) materials is based on approximation and the actual figures will depend on the size and the rate at which the activity will be undertaken at the district level. For example, in a district with around 2000 Accredited Social Health Activists (ASHAs), 10 000 posters may be printed @5 posters per ASHA area. This is just an approximation and actual numbers may vary depending upon the number of ASHAs per district and the rate which is charged for the printing of the poster.

5.2.4 Block communication plan

This plan describes some indicative communication activities under the different components on a similar pattern as for the state and district level plans. Under demand generation, suggested strategic locations for display and dissemination of mid media materials have also been given for enhanced visibility of messages. The plan also includes proposed activities for interpersonal communication and community mobilization along with capacity-building, coordination, and advocacy and social mobilization initiatives.

Communication activities at the block level will include the following

- Capacity building
  - IPC skills training of frontline functionaries (ANMs, ASHAs and AWWs)
  - Orientation of nodal school teachers on routine immunization
  - Orientation of NGO volunteers on routine immunization
- Advocacy engagements with religious leaders, PRI members, SHG members and key influencers such as teachers, local doctors, CSOs, NCC and NSS
- Social mobilization
  - Community meetings
  - Temple/mosque announcements
  - Rallies
  - Miking
  - Nukkad natak/street plays
  - Stalls on routine immunization in local gathering (*haat, mela, sammelan, urs)*
  - Organize health camps in hard-to-reach/underserved areas/resistant pockets
  - Social mobilization campaigns through community networks such as CBOs, community influencers, religious leaders, NGOs, youth volunteers, SHGs and cooperatives
- Monthly meetings (or as is considered necessary) with ICDS, PRI and allied departments for intersectoral convergence.

5.2.5 Community-level communication plan

A communication plan should be developed for the sessions planned under Mission Indradhanush. The following activities may be undertaken to enhance community awareness for Mission Indradhanush and acceptance for routine immunization:

- Local miking on slow moving vehicles
- Drum beating/munadi
- Announcements from locally situated religious places
- Community radio spots
- Mothers' meetings
- Self-help group meeting
- Youth clubs
- Community meetings (with pradhans, ward members, village level influencers)
- Schools, club rallies
- Display of banners and posters
- Home visits by local mobilizers (ASHAs/AWWs) for IPC

5.2.6 Role of the local influencer(s)

Doctors, village pradhans or urban ward members, panchayat secretary, ration dealers, religious leaders and teachers play an important role in facilitating vaccine acceptance in community. These influencers play a key role in creating vaccine awareness and clearing doubts regarding vaccination, thereby enhancing vaccination coverage. ANM with support from ASHA, AWW and other mobilisers will identify local influencers for each session site. These influencers should be available to help mobilisers on the day of vaccination and committed to support the team. They may also support mobilisers in organizing rallies, bulawwa tolis as well as announcement from mosques and other places.

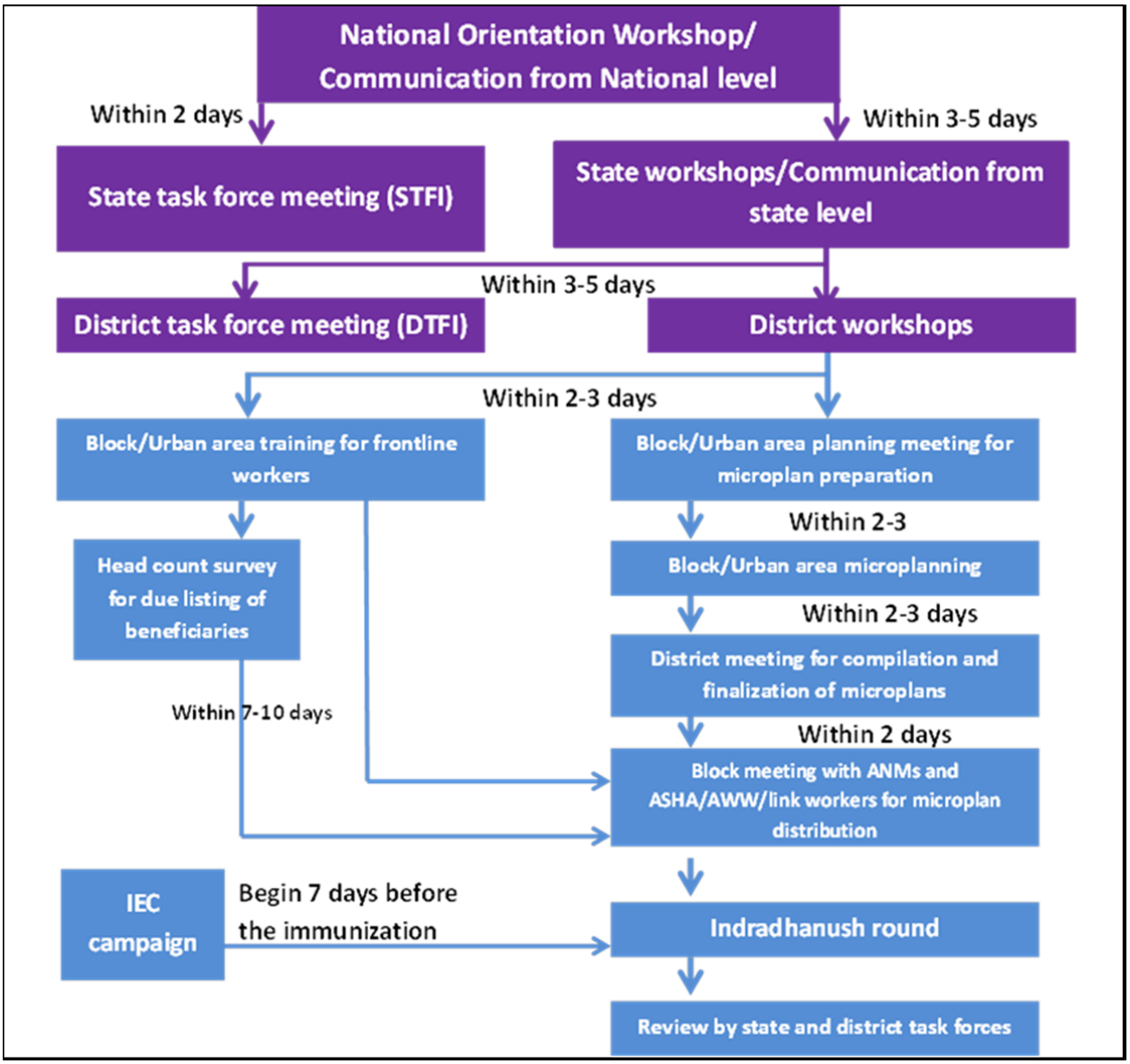
On the day of immunization, mobilisers should be invited to inaugurate the session. After session inauguration, influencers and mobilisers must visit houses of beneficiaries as per due list and ensure vaccination of all eligible beneficiaries in the area.

Names of all identified influencers should be incorporated in micro-plans. Interface meeting of mobilisers, vaccinators and influencers should be organized at least one week prior to immunization day for sensitizing influencers on Mission Indradhanush, importance of their engagement and sharing beneficiary due list. Responsibility of beneficiary mobilization should be rationally divided among influencers so that they have manageable workload of influencing parents of beneficiaries for vaccination.

STEPS FOR ROLL-OUT OF MISSION INDRADHANUSH

The roll-out of Mission Indradhanush requires meticulous planning at all levels. Special sessions under Mission Indradhanush should be conducted in areas that are unreached or poorly reached for routine immunization services to ensure maximum improvement in full immunization coverage of states. Prior to conducting these sessions, headcount must be done in such areas for enlisting beneficiaries and preparing due lists. The steps for rolling out Mission Indradhanush have been illustrated in Figure 2.

Figure 2. Steps for roll-out of Mission Indradhanush



STATE LEVEL ACTIVITIES FOR MISSION INDRADHANUSH

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

7.1 Meeting of State Task Force for Immunization (STFI)

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

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

Chairperson: Principal Secretary, Health

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

Member Secretary: State Immunization Officer (SIO)

Responsibility: Director, Family Welfare; SIO

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: At least one meeting before each Mission Indradhanush round

Review mechanism: MoHFW will review the activity.

Activities to be conducted:

- Provide technical guidance, including funding and operational guidelines, and fix timelines for districts to plan and implement immunization weeks.
- Communicate with district magistrates for conducting meetings of DTFI and district workshop for Mission Indradhanush after the state workshop.
- Involve other relevant departments including ICDS, PRI and key immunization

Critical activity: Mission Indradhanush preparedness / progress review

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

STFI to closely monitor quality of DTFIs

Frequency: at least once before each round

partners such as World Health Organization (WHO) India, National Polio Surveillance Project (NPSP), United Nations International Children's Fund (UNICEF), Rotary International, Reproductive, Maternal, Newborn, Child Health and Adolescent Health (RMNCH+A) lead partners and other organizations at state and district levels. CSOs, including professional bodies such as IMA and IAP, should also be involved.

- Ensure identification of the nodal officer for urban areas in each district. He/she will facilitate microplanning in urban areas of the district.
- Ensure adequate number of IEC materials (as per prototypes) and updated planning and reporting formats are printed and disseminated to districts in time. Ensure that these materials are printed in local languages if required.
- Deploy senior state-level health officials to high-focus districts for monitoring and ensuring accountability framework. They should visit these districts and provide oversight to activities for roll-out of Mission Indradhanush, including participation in DTFI meetings and assessment of district preparedness.
- Track districts for adherence to timelines, including microplanning, indenting of vaccines and logistics, and roll out of Mission Indradhanush. All districts should conduct these drives on a common date.
- Fix date and time and conduct video conferences with districts and urban local bodies to review and resolve issues related to microplanning, vaccines and logistics, human resources availability, training, waste management, AEFI and IEC/BCC. District participants will include district magistrate, chief medical officer (CMO), district immunization officer (DIO) and nodal officer for the urban area.
- Review each round of Mission Indradhanush and guide corrective actions.
- Ensure inclusion of Mission Indradhanush sessions in regular routine immunization plans.
- Minutes and actions taken report of each meeting should be circulated to officials concerned and communicated to MoHFW, GoI.

7.2 State workshops and review

The objective of state workshops is to build capacity of district officials in cascading trainings at district and block levels. The trainee officials will be oriented on conducting planning exercises that emphasize on head count survey and preparation of due list of beneficiaries. These workshops also aim at strengthening social mobilization among communities, and ensuring accountability and effectiveness of government programmes.

Responsibility: State Immunization Officer

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

Financial support: Through NHM

Timeline: Within 3-5 days after receiving official communication from the national level.

Participants: DIO and one MO from each district

Review mechanism: MoHFW will review the activity.

Activities to be conducted:

- Train district-level trainers on use of updated planning formats for Mission Indradhanush, reporting and recording tools such as revised immunization component in mother-child protection (MCP) card, registers, due lists and tally sheets, immunization tracking bag (one per session site to be used by ASHA/AWW).
- State health authorities and partners should intensively monitor training for quality and attendance and share findings with STFI.
- Post district-wise progress of training status on the website of the state health department.
- Details of trainings to be conducted at state level are given in Table 1.

Table 1. State-level workshops and review

S.No.	Trainees/ Participants	Trainers/ facilitators	Duration	Timeline
1	**MOs**: DIO and one MO from each district (two persons per district). Also include SMOs of WHO India NPSP, UNICEF district coordinators and others such as state programme manager (NHM), state IEC consultant, state ASHA coordinator, state cold chain officer, state data manager, state M&E coordinator (NHM), state finance & accounts manager (NHM) Financial support: NHM	SIO with support from state cold chain officer, HMIS and MCTS coordinators, IEC consultant and partners such as WHO India NPSP, UNICEF and others	One-day workshop	Within 3-5 days after official notification from MoHFW
2	**Mission Indradhanush media sensitization meeting:** Workshop for sensitization of media (print/electronic). Financial support: NHM	SIO with support from UNICEF, Rotary, WHO India NPSP and other partners, state IEC consultant and media officer. Principal Secretary to chair and MD NHM to co-chair the meeting.	Half-day workshop	At least 1 week prior to the launch
3	**Mission Indradhanush review workshops:** Review of districts to be done in between the rounds of Mission Indradhanush by meetings/ video conferencing. Financial support: NHM	SIO with support from UNICEF, Rotary, WHO India NPSP and other partners. Principal Secretary to chair and MD NHM to co-chair the meeting.	Half-day workshop	Between the rounds

ASHA: accredited social health activist; DIO: district immunization officer; HMIS: health management information system; IEC: information, education and communication; MCTS: mother and child tracking system; MD NHM: Mission Director, National Health Mission; MO: medical officer; SIO: state immunization officer; SMO: surveillance medical officer

DISTRICT LEVEL ACTIVITIES FOR MISSION INDRADHANUSH

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

8.1 Meeting of District Task Force for Immunization (DTFI)

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

Chairperson: District Magistrate

Member Secretary: DIO

Responsibility: DIO

Timeline: Within 3-5 days of state workshop/ communication from the state level.

Frequency: At least one DTFI meeting should be organized prior to each round of Mission Indradhanush, and more frequently if required, to review progress in planning and implementation.

Review mechanism: STFI

Activities to be conducted:

- Provide technical guidance, including funding and operational guidelines, and fix timelines for blocks to plan and implement immunization weeks.
- Involve other relevant departments including ICDS, PRI and key immunization partners such as WHO India NPSP, UNICEF, Rotary International, RMNCH+A lead partners and other organizations at state and district levels. CSOs, including professional bodies such as IMA and IAP, should be involved.
- Ensure identification of nodal officer for urban areas in the district. He/she will facilitate microplanning in urban areas of the district.
- Ensure adequate number of printed IEC materials (as per prototypes) and updated reporting and recording tools (MCP cards, registers, due lists, tally sheets) are printed and disseminated to blocks/planning units in time. Ensure that these materials are discussed and used in the sensitization workshops.

Critical activity: Mission Indradhanush preparedness / progress review

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

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

- Deploy senior district-level health officials to priority blocks for monitoring and ensuring accountability framework. They should visit these blocks and provide oversight to activities for roll-out of Mission Indradhanush, including participation in training, monitoring of activity and participation in evening review meetings.
- Ensure availability of required doses of all UIP vaccines and other logistics. This will require a headcount for estimation of beneficiaries in all areas where Mission Indradhanush sessions are planned.
- Track blocks and urban areas for adherence to timelines, including microplanning, indenting of vaccines and logistics and launch of each round of Mission Indradhanush.
- Communicate to Principal Secretary (Health) in case dates of Mission Indradhanush rounds need to be changed due to exceptional circumstances.
- Review microplans to ensure engagement of all ANMs for 7 working days in addition to routine immunization days.
- Vaccines and logistics, human resources availability, mobility of vaccinators when conducting session outside sub-centre area, training, waste management, AEFI and IEC/BCC.
- Review each round and guide corrective actions.
- Ensure inclusion of Mission Indradhanush sessions in regular routine immunization plans
- Conduct daily evening feedback meetings during the round at the district for sharing feedback and initiating corrective actions.
- Minutes and action taken report of each meeting should be circulated to officials concerned and communicated to MoHFW, GoI.

8.2 District workshops

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

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

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

Financial support: WHO India NPSP will support district workshops for MOs in all 216 high focus districts. One-hour training of NHM officials, half-day trainings of data handlers and cold chain handlers and media workshop will be financially supported through NHM funds.

Timeline: Before Mission Indradhanush

Participants: Two MOs from each block and urban planning unit

Review mechanism: DTFI and STFI

Activities to be conducted:

- Train block-level trainers on use of updated planning formats for Mission Indradhanush, reporting and recording tools such as revised immunization component in mother-child protection (MCP) card, registers, due lists and tally sheets, immunization tracking bag (one per session site to be used by ASHA/AWW).
- This pool of trainers will conduct sub-district level training of the health workforce including health workers and supervisors (ANMs, lady health visitors [LHVs] and health supervisors) and community mobilizers (ASHAs, AWWs and link workers).
- Sensitize key district-level NHM officials on Mission Indradhanush.
- Submit progress on training status of each level of functionary to the state immunization officer before the first round of Mission Indradhanush. Repeat trainings in weak performing areas, with focus on weak performing vaccinators/mobilizers.
- Details of training to be conducted at the district level are given in Table 2.

Table 2. District-level workshops

S.No.	Trainees	Trainer	Duration	Timeline
1	**MOs**: Two MOs per block/urban planning unit. Nominations to be forwarded to DIO. Others include district programme manager (NHM), district IEC consultant, district ASHA coordinator, district cold chain handler, district data manager, district M&E coordinator (NHM), district accounts manager (NHM) Technical and financial support for workshop: WHO	DIO and another MO trained at state level and partners (WHO India NPSP, UNICEF and others)	One-day workshop	Within 1 week after completion of STFI meeting
2	**Programme/Accounts managers (NHM)**: District and block programme and accounts managers and other officials handling NHM funds Financial support: NHM	DIO and trained MO, with support from district programme manager, district accounts manager, district M&E coordinator and partners (WHO India NPSP, UNICEF and others)	1 hour	After completion of district MO workshop
3	**Data handlers**: One data handler involved in immunization data entry (HMIS and MCTS data) per district/block/planning unit Financial support: NHM	DIO and other MO trained at state level. District M&E Coordinator (NHM) and partners (WHO India NPSP, UNICEF and others)	Half-day workshop	Within 1 week after completion of district

4	**Vaccine and cold chain handlers**: Block/planning unit to identify and nominate at least two persons per vaccine storage point. Nominations to be forwarded to DIO. Financial support: NHM	DIO and trained MO with district cold chain handler and partners (WHO India NPSP, UNICEF and others)	Half-day workshop	worksho p
5	**Mission Indradhanush media workshop:** Workshop for sensitization of media (print/electronic). DIO, with support of partners, to prepare the agenda and list of invitees. Financial support: NHM	DIO with support from UNICEF, Rotary, WHO India NPSP and other partners, district IEC consultant, media officer. District Magistrate to chair the meeting.	Half-day workshop	At least 1 week before launch

ASHA: accredited social health activist; DIO: district immunization officer; HMIS: health management information system; IEC: information, education and communication; MCTS: mother and child tracking system; NHM: National Health Mission

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

BLOCK LEVEL ACTIVITIES FOR MISSION INDRADHANUSH

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

9.1 Training of frontline workers

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

Responsibility: Block MO IC

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

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

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

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

Review mechanism: DTFI

Activities to be conducted:

- **Training of ANMs/LHVs/health supervisors**
    - In sub-centres with two ANMs, a clear division of area between the two ANMs must be done to ensure maximum output and accountability. Sub-centre with delivery facilities may plan accordingly.
    - Updated reporting and recording tools, including Mission Indradhanush microplanning and reporting forms, revised counterfoil of MCP card, tracking bag, due lists, tally sheets and registers will be shared during the training workshops.
    - One-page info kit on Mission Indradhanush planning and operationalization will be provided to ANMs during the training.
    - Printed IEC materials, including street and session site banners and posters, will be provided to ANMs for display at session sites.
    - Preparation of microplans by each ANM for conducting Mission Indradhanush sessions within own block.

- **Training of mobilizers (ASHAs, AWWs and link workers)**
    - Block ASHA coordinator and child development project officer will support MOs and representatives from partner agencies in conducting these training sessions.
    - Mobilizers will be trained on headcount for estimation of beneficiaries.
    - Mobilizers will be expected to conduct this survey in their assigned area, and if required, outside their area as well. Financial support will be provided for conducting this exercise as per norms (Annexure 7).
    - Financial support will also be disbursed by MO IC of the block for mobilization of beneficiaries to session sites by mobilizers (ASHAs/AWWs/link workers) as per attached norms (Annexure 7).
    - Details of trainings to be conducted at the block level are given in Table 3.

Table 3. Block-level training workshops/ToTs

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

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 5 and 6 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.

FREQUENTLY ASKED QUESTIONS FOR MISSION INDRADHANUSH

Q1. What is Mission Indradhanush?

Mission Indradhanush is a flagship programme of the Ministry of Health & Family Welfare. It aims at improving the full immunization coverage in the country from the current 65% to more than 90% through special immunization drives, with special attention to 216 identified high-focus districts.

Q2. When will Mission Indradhanush drives be conducted during phase III?

Special routine immunization drives under Mission Indradhanush will be conducted across the country in all districts. Each drive will be conducted for up to 7 days, with a gap of at least 4 weeks between the two drives. During phase III, four special drives will be conducted between April and July 2016, with focus on 216 high-focus districts.

Q3. What areas will be prioritized for coverage in the identified high/medium focus districts under Mission Indradhanush?

The Mission will focus on the following key areas:

1. Areas with vacant sub-centres: No ANM posted for more than 3 months.
2. Villages/areas with three or more consecutive missed routine immunization sessions: ANMs on long leave or other similar reasons
3. High-risk areas identified by the polio eradication programme that are not having independent routine immunization sessions and clubbed with some other routine immunization sessions.
4. These include populations living in areas such as:
   - urban slums with migration
   - nomadic sites
   - brick kilns
   - construction sites
   - other migrant settlements (fisherman villages, riverine areas with shifting populations, etc.)
   - underserved and hard-to-reach populations (forested and tribal populations, etc.).
5. Areas with low routine immunization coverage (pockets with recent measles or other VPD outbreaks)
6. Small villages, hamlets, *dhanis* or *purbas* clubbed with another village for routine immunization sessions and not having independent routine immunization sessions.

Q4. Why has my district been included for Phase III of Mission Indradhanush?

A total of 201 high-focus districts were identified for Phase I of Mission Indradhanush based on extensive analysis. Subsequently, phase II was conducted in 352 districts (73 districts repeated from phase I) of the country. High focus (phase I) districts where independent monitoring indicated that more than 90% children had received all due vaccines have been excluded, while Phase II districts where less than 60% of the children had received all due

vaccines have been included for Phase III. The 216 high-focus districts were identified based on monitoring indicators and feedback from states.

Similar method will be followed for district selection in subsequent phases of the Mission Indradhanush.

Q5. How will the number of beneficiaries for these drives be estimated?

The beneficiaries for Mission Indradhanush will be estimated based on a head count survey that will be conducted by ASHA/AWW/link worker in all areas identified to be covered under Mission Indradhanush. An incentive of Rs 100 is available under NHM for this activity. For details, see financial guidelines (Annexure 7).

Q6. Will this head count be conducted in the entire district before phase III of Mission Indradhanush?

No, the head count for estimation of beneficiaries will be conducted only in areas where Mission Indradhanush sessions will be planned. An incentive of Rs 100 will be given to ASHA/AWW/link worker for this exercise, once before the first round and once for revision after the second round.

Q7. All small hamlets, brick kilns, construction sites, nomadic sites, slums etc. in my sub-centre area are tagged to the existing session sites. What is the need to conduct additional sessions in such areas?

Despite tagging of HRAs, it is often observed that beneficiaries do not reach the session sites. Planning additional sessions close to residences of targeted beneficiaries in HRAs and other identified areas during Mission Indradhanush rounds provide another opportunity to immunize children, especially the left outs and drop outs.

Q8. In Mission Indradhanush, is ANM eligible to claim any TA/DA for working outside her place of posting?

Yes, ANM working outside her place of posting during Mission Indradhanush is eligible to claim TA/DA as per the state TA/DA rules.

Q9. How will sites like brick kilns or construction sites be covered during these drives?

Sites with a small number of beneficiaries that do not require independent sessions can be covered by mobile vaccination teams. More than one site may be covered by a mobile team. However, it must be ensured that vials of BCG, Measles, Rotavirus vaccine (RVV) and JE opened at one site are discarded and not used at the next site.

Q10. Will any special training be provided for this drive?

Yes, all health workers will be trained on the planning and implementation of Mission Indradhanush. ASHAs/AWWs/link workers will be trained on conducting the head count survey for estimation of beneficiaries and communicating with families of beneficiaries. District/Block level trainers who participated in district Mission Indradhanush workshops will be responsible for training all frontline workers and mobilizers involved in implementation of Mission Indradhanush.

In addition, training should be provided to data handlers, cold chain handlers and supervisors.

Q11. How will immunization sessions be planned during 7 days of the Mission Indradhanush round?

All ANMs should be involved in conducting sessions for Mission Indradhanush. They should dedicate 7 working days to Mission Indradhanush sessions, in addition to routine immunization days. The routine immunization sessions planned in between the 7 days of Mission Indradhanush should not be disturbed and should be held as planned.

For Mission Indradhanush round, ANM may be deployed within or outside her block in her district of posting for conducting Mission Indradhanush sessions. This mechanism will tackle the existing human resource issues within the district.

Q12. What will be the timings of sessions?

The session sites will be operational from 09:00 to 16:00. However, flexibility based on the availability of beneficiaries or other local conditions is permitted.

Q13. Will all UIP vaccines be provided in Mission Indradhanush rounds?

Yes, all vaccines that are being provided under UIP in the state/district as per the national immunization schedule will be made available under Mission Indradhanush.

Table 4. National Immunization Schedule

Age	Immunization Schedule	Remarks
At birth	BCG, OPV-0, Hep B-birth dose	(1) BCG vaccine can be given up to 1 year of age. (2) DPT vaccine can be given up to 5-6 years (not beyond 7 years) of age. (3) Pentavalent vaccine should be given under 1 year of age. In delayed cases , due doses above 1 year of age can be given to a child only if a child has received at least one dose of pentavalent vaccine before his/her first birthday. Due doses should be given at a minimum interval of 4 weeks, at the earliest available opportunity. (4) Measles vaccine can be given up to 5 years of age. (5) JE vaccine can be given up to 15 years of age. (6) IPV* should be given as per immunization schedule upto 1 year of age. - single dose of IPV at 14 weeks of age along with OPV3 (in 28 states/UTs) - two fractional doses of IPV at 6 & 14 weeks (in 8 states (Odisha, Maharashtra, Tamil Nadu, Telangana, Karnataka, Kerala, Puducherry & Andhra Pradesh) (7) Rotavirus vaccine (RVV) should be given at 6, 10 & 14 weeks. It can be given up to 1 year of age. (in four states: Andhra Pradesh, Haryana, Himachal Pradesh and Odisha)
6 weeks	OPV1/Pentavalent1/RVV1 (in selected states)	
10 weeks	OPV2/Pentavalent2/RVV2 (in selected states)	
14 weeks	IPV*, OPV3/Pentavalent3/RVV3 (in selected states)	
9 months	MCV1; JE-1 (where applicable)	
16-24 months	MCV2; DPT first booster dose; OPV booster dose; JE-2 (where applicable)	
5-6 years	DPT second booster dose	
10 years	TT	
16 years	TT	

BCG: *Bacillus Calmette-Guerin*; DPT: diphtheria-pertussis-tetanus; Hep B: Hepatitis B; Hib: *Haemophilus influenzae* type b; JE: Japanese Encephalitis; MCV: measles alone or MR/MMR; OPV: oral polio vaccine; TT: tetanus toxoid; IPV: inactivated poliovirus vaccine; RVV: Rotavirus vaccine

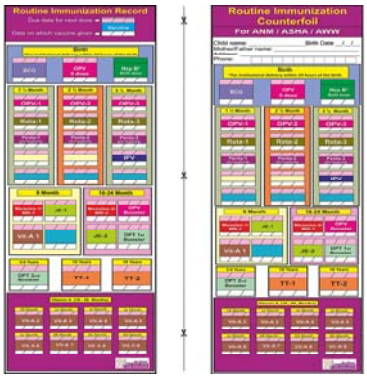
Q14. Will IPV vaccine be provided during these drives in states that have introduced the vaccine?

Yes, the states that have introduced IPV vaccine in the immunization schedule will provide the vaccine to beneficiaries. Migrant beneficiaries from other states will also be provided all vaccines being given under UIP. For example, JE vaccines will be given to beneficiaries from other states in a JE endemic district; IPV vaccine will be given to children (as per GoI guidelines) from migrant families when they are availing services in a state that has introduced IPV vaccine. In 28 states/UTs, single dose of IPV will be administered at 14 weeks of age along with OPV3. However, in 8 states (Odisha, Maharashtra, Tamil Nadu, Telangana, Karnataka, Kerala, Puducherry & Andhra Pradesh) IPV should be given as two fractional intradermal doses at 6 and 14 weeks.

Q15. How will all vaccines be delivered to the session sites for Mission Indradhanush?

All vaccines and logistics will be delivered to session sites through alternate vaccine delivery mechanism. The same mechanism will be used to return all unused and partially used vaccine vials, along with the session report, to block PHC/urban health post.

Q16. Will any different vaccination card be given to the beneficiaries of Mission Indradhanush?

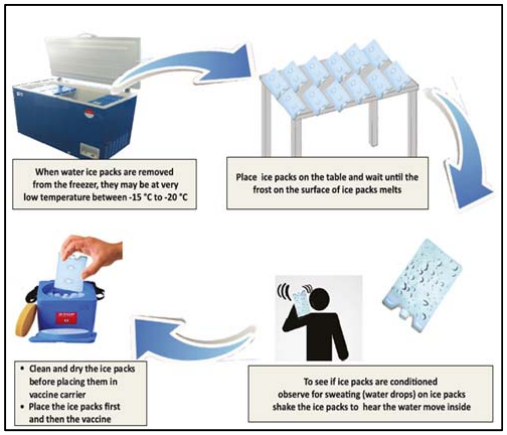


No, there is no different vaccination card for Mission Indradhanush. The MCP card with the revised immunization component used under the UIP will be used for Mission Indradhanush. If any beneficiary is getting vaccination for the first time or has lost the previous card, a new card should be issued.

Q17. Will open vial policy be applicable in Mission Indradhanush?

Yes, open vial policy will be applicable to OPV, IPV, Hepatitis B, DPT, TT and pentavalent vaccines. Open vial policy is not applicable to BCG, Measles, Rotavirus vaccine (RVV) and JE vaccines. Do not forget to write the date and time of opening vial on the label.

Q18. Will ice packs used in the vaccine carriers during Mission Indradhanush drives be "hard frozen" or "conditioned"?



Only conditioned ice packs should be used in routine immunization as well as for Mission Indradhanush drives as IPV, DPT, Hepatitis B, pentavalent and TT vaccines are freeze-sensitive vaccines. When placed in a vaccine carrier with hard frozen ice packs, these vaccines may freeze and lose their potency. Also, BCG, OPV, measles and JE vaccines can be safely transported with conditioned ice packs.

Q19. Will the guidelines for taking out one ice pack during the routine immunization session be valid for Mission Indradhanush drive as well?

Yes, the vaccinator should take out one ice pack and place vaccines as shown in picture.

Q20. How will these drives be monitored?

These drives will be monitored by independent agencies including WHO, UNICEF, UNDP, ITSU, JSI, GHS, CORE and other lead partner agencies of RMNCHA in high priority districts. Besides these agencies, observers from national, state and district levels will also intensively monitor these drives. Feedback will be provided to the state and district task forces for immunization to ensure corrective actions.

Based on monitoring and coverage feedback, Mission Indradhanush will closely be reviewed by District Magistrate/Chief Medical Officer at the district level, Chief Secretary/Principal Secretary/Mission Director (NHM) at the state level, and Secretary/Additional Secretary & Mission Director (NHM)/Joint Secretary/Immunization division at the national level. The progress of Mission Indradhanush is being reviewed periodically by the Prime Minister Office (PMO) as part of "PRAGATI".

Q21. How will the reporting of Mission Indradhanush drive take place from ANM to block to district to state and to national level?

For Mission Indradhanush, the reporting from ANM upwards till state is to be done on a daily basis. The state will compile district-level reports and share the compiled report with national level on the next day.

Q22. Does the district need to include routine immunization coverage report for sessions held during Mission Indradhanush round?

Under Mission Indradhanush coverage reporting, the district should not include the coverage of routine immunization sessions that were held during Mission Indradhanush. To explain better, if routine immunization sessions are being held in between the Mission Indradhanush drive, the daily coverage report of Mission Indradhanush district will not include the routine immunization coverage achieved during those days, i.e., only immunization coverage achievement done under Mission Indradhanush session should be forwarded to the next level right up to

- **Mission Indradhanush daily and cumulative coverage report should only include the coverage done in Mission Indradhanush sessions.**
- **This also means that Mission Indradhanush coverage report should be exclusively for Mission Indradhanush and should not include the coverage done during the routine immunization sessions held in between the Mission Indradhanush drive.**

national level. Reporting of Mission Indradhanush coverage for every round should be based on the coverage achieved for that day. The final coverage report of Mission Indradhanush will include only the coverage of Mission Indradhanush drive.

Q23. Should Mission Indradhanush coverage be reported in the HMIS?

Yes, Mission Indradhanush coverage should be included as part of the monthly coverage reporting in HMIS. In other words, it means that the achievement under Mission Indradhanush and routine immunization for that given month should be jointly reported in HMIS as one report. HMIS portal does not have a separate data entry field for reporting Mission Indradhanush achievement.

Ensure that at the month end Mission Indradhanush coverage should be included as part of the monthly coverage reporting in HMIS

Q24. Should planned Mission Indradhanush sessions become a part of routine immunization microplan?

Yes, planned Mission Indradhanush sessions should be incorporated in routine immunization microplanning soon after the completion of mission. Mission Indradhanush microplanning concept is based on potentially weak or priority areas for routine immunization. State should collect data for such inclusion and inform GoI. This revision in routine immunization microplanning must be discussed in DTFI and STFI for effective implementation.

Q25. How should we plan for Mission Indradhanush sessions in vacant sub-centre areas?

All ANMs in the district will be working for 7 days of Mission Indradhanush, in addition to the routine immunization days. The ANMs will be deployed, based on need, to the vacant sub-centre areas for conducting immunization sessions. After completion of Phase III of Mission Indradhanush, the additional sessions that are planned in such vacant sub-centre areas should be assigned to ANM/s from adjoining sub-centres or by deploying hired vaccinators.

Some anticipated scenarios related to Mission Indradhanush

SCENARIO	WHAT SHOULD YOU DO
1. If Mission Indradhanush round start date coincides with routine immunization day in state. What needs to be done in such a case?	• In such a case, the planned routine immunization sessions will not be disturbed and will be held as planned. • As per guidelines, ANM should plan to conduct Mission Indradhanush sessions on 7 working days in addition to routine immunization days, excluding Sundays and government holidays. • Coverage data of routine immunization sessions will be reported separately from that of Mission Indradhanush coverage report. • At the end of month, the Mission Indradhanush round coverage data and routine immunization data should be added and entered together in the HMIS.

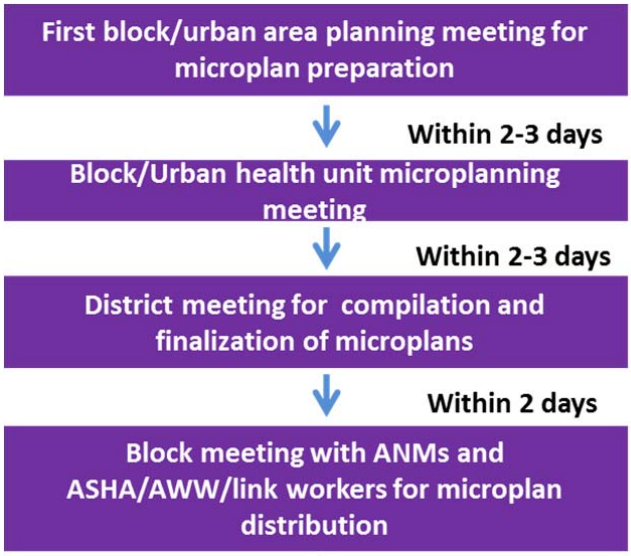
2. How Mission Indradhanush sessions should be planned at a sub centre where two ANMs are posted?	• Coverage area should be well demarcated between two ANMs. • Each ANM will plan Mission Indradhanush sessions on 7 working days, excluding routine immunization days, Sundays and government holidays. • Sub-centres with delivery facilities should plan accordingly. • Each of these two ANMs will submit separate Mission Indradhanush coverage reports each day.

STEPS FOR PREPARATION OF MICROPLANS FOR MISSION INDRADHANUSH

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

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

Within 2-3 days of completion of district workshops, the following steps should be undertaken for preparing a complete microplan for Mission Indradhanush sessions:



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

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

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

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

Activities to be conducted:

- Prepare a master list of all villages/hamlets/HRAs etc. using the existing routine immunization microplans, polio microplans, census list of villages/hamlets, list of polio HRAs (slums, nomads, brick kilns, construction sites and other non-migratory HRAs), list of areas with measles or diphtheria outbreaks in the last two years (with any reported measles death) and monitored areas for routine immunization with sub-optimal performance.

- ANMs will be provided blank microplanning format 1 (Annexure 8) to list all areas and subsequently identify areas requiring additional sessions under Mission Indradhanush in their own sub-centre areas.
- During the following 2-3 days, ANMs should list all HRAs (villages, hamlets, slums, nomadic sites, brick kilns, construction sites, other high-risk settlements) on the ANM microplanning format 1 (Annexure 8). Once all areas are listed, ANMs will identify areas where the number of unvaccinated (left outs) and partially vaccinated (drop outs) children up to 2 years of age is high and require additional sessions. Enlisting of beneficiaries will require ASHA/AWW/link worker support for headcount survey.

Step 2. Block/Urban health unit microplanning meeting

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

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

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

Activities to be conducted:

- ANMs will bring filled microplanning format 1 (Annexure 8) during training at the block level. This will be reviewed by the trainer and amended if required.
- Block/health post MO IC will identify areas that require additional routine immunization sessions from all sub-centres. MO IC will enlist all such areas in microplanning format 2 (Annexure 8) and also determine whether these sites will be covered through outreach sessions or mobile sessions.
- Each ANM will prepare a roster using microplanning format 3 (Annexure 10) for additional sessions in her own sub-centre area in consultation with the Block MO IC. For Mission Indradhanush days, she can be assigned areas outside her sub-centre area for a maximum of 7 days of Mission Indradhanush activity.
- Once the ANM has prepared her roster for areas requiring additional Mission Indradhanush sessions in her own sub-centre area, MO IC 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. MO IC will assign such areas to other ANMs in the block for the remaining days of the Indradhanush round. This assignment should be done keeping in mind the travel time and feasibility of this assignment. These assigned sessions will be included by ANMs concerned in their roster for the round.
- Such ANMs working in other sub-centre areas may be supervised by a different supervisor.

- Plan to engage all ANMs during the Mission Indradhanush drive.
- ASHAs/AWWs/link workers will be assigned to each session in consultation with the block ASHA coordinator. The ASHA manager will ensure that headcount is conducted for estimation of beneficiaries in additional areas assigned to a mobilizer. Ensure that this is a time-bound activity (1 week) and its progress is monitored by DTFI. MO IC will monitor and provide oversight to this activity.

In urban areas:

- Identify Nodal officer for immunization activities in urban areas for Mission Indradhanush
- Nodal officer will demarcate the urban area into the catchment area of available health posts. He/she will then identify the available health manpower (ANMs/public health nurses/health supervisors) in each health post.
- Considering 2–3 polio team days as one unit, each health post in-charge will map and list each such unit in microplanning format 1 (Annexure 8).
- Once all areas are listed, health post in-charges will identify areas where numbers of unvaccinated (left outs) and partially vaccinated (drop outs) beneficiaries require additional sessions (posh colonies/areas with high routine immunization coverage will not be included in this planning). All such areas will be listed in microplanning format 2 (Annexure 9).

Step 3. District-level microplan finalization meeting

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

Participants: Two MOs from each block and urban nodal officers

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

Activities to be conducted:

- Each block medical officer-in charge (MO IC) and nodal officer (in urban areas) will carry microplanning Form 2 of his/her block/urban area along with microplanning Form 3 (ANM roster for Mission Indradhanush) for all ANMs in the block.
- Nodal officer in urban areas will discuss the number of sessions that have not been assigned to any ANM/vaccinator.
- DIO will assess the number of sessions in each block and all urban areas that have not been assigned to any ANM/vaccinator. He/she will also assess the number of ANM days available with each block/urban area that may be handed over to another block/urban area.

- ANMs with one or more days available during Mission Indradhanush week can be assigned to another block/urban area for conducting routine immunization sessions during this drive. This assignment should be done keeping in mind the travel time and feasibility of this assignment.
- These assigned sessions will be included in the ANM roster (microplanning Form 3) of ANMs by their MO ICs concerned.
- Such ANMs working in other sub-centre areas may be supervised by a different supervisor.
- This meeting will also allow the DIO to review the requirement of mobile units for conducting vaccination sessions in blocks/urban areas.
- DIO will also assess the requirement of hiring vaccinators for conducting sessions during this drive.

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

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

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

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

Activities to be conducted:

- MO ICs of blocks and 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 10) will be filled with the following:
    - Areas included in ANM's sub-centre with weak routine immunization coverage, where she will conduct routine immunization sessions on the two routine immunization days designated by the state (as stated in the example above). Sessions that ANM will conduct in the neighbouring block/urban area on the remaining days of Mission Indradhanush round. During these days, she will be supervised by the supervisor designated for that particular area.
- The ANM concerned will need to discuss details (how to reach designated area, where to pick up vaccines) with the supervisor of the area. Details of the mobilizer (name and contact number) will be available in the ANM roster for Mission Indradhanush rounds.

- Each ANM will send her tally sheet to the block through the alternate vaccine delivery (AVD) mechanism on a daily basis so that reports can be compiled and submitted to the district on a daily basis.
- Monitoring feedback for the ANM will be shared with the MO IC of the planning unit where she is working for the day. MO will share feedback of the MO IC of the block where the ANM is posted.

VACCINES AND LOGISTICS MANAGEMENT

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

National switch date is 25 April 2016: Do not use tOPV after the switch date

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

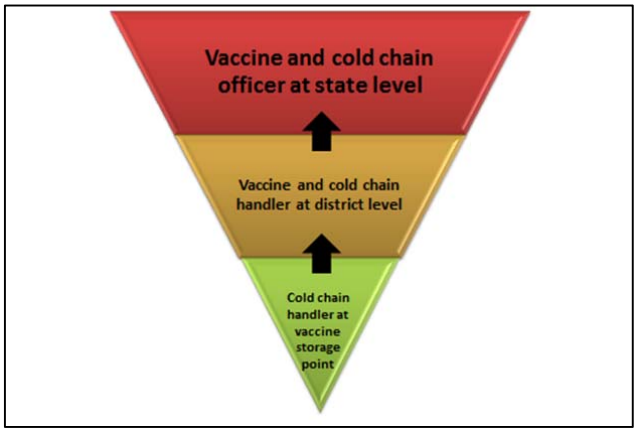
Any new vaccine introduced will be a part of Mission Indradhanush.

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

12.1 Estimating vaccines and syringes needed

- Logistics including auto-disable (AD) syringes and MCP cards available under the existing UIP programme will be used for Mission Indradhanush.
- As each AD syringe is packed separately, hence, maximum permissible wastage rate for AD syringes equal to vaccine doses supplied including wastage.
- Estimation of vaccine and logistics requirements should be done on the existing formats, based on the estimation of beneficiaries.

Figure 3. Vaccine/Diluent reporting for Mission Indradhanush



- PHCs and districts need to forecast their vaccine needs for the stipulated time period to ensure that the right amount of vaccine, AD syringes and cold chain equipment are available to vaccinate all eligible beneficiaries in the identified areas at a given time.
- DIO will be responsible for ensuring availability of required stock of vaccine and logistics for the Indradhanush sessions. Buffer stocks should be maintained as per recommendations.
- In case of any vaccine or logistic shortage at any session during the Indradhanush week, the ANM will contact the supervisor, who will arrange the required vaccine(s)/logistics from the nearby session or planning unit. Shortage at the block must promptly be replenished from the district level. In case of any shortage at district level, SIO will be informed for necessary action.
- The monitoring of vaccines and logistics can be done through eVIN in the states of Uttar Pradesh, Bihar and Madhya Pradesh.

The reporting chain for vaccines/diluents is given in Figure 3.

12.2 Vaccine wastage

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

Summary: Wastage permissible for all vaccines In Routine immunization

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

12.3 Cold chain space and inventory

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

In states that have introduced the pentavalent vaccine, cold chain space availability has increased due to the reduced requirement of DPT and hepatitis B vaccines. With this freed capacity, there is no constraint envisaged on the cold chain capacity for storage of IPV.

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

12.4 Cold chain monitoring

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

12.5 Vaccine storage

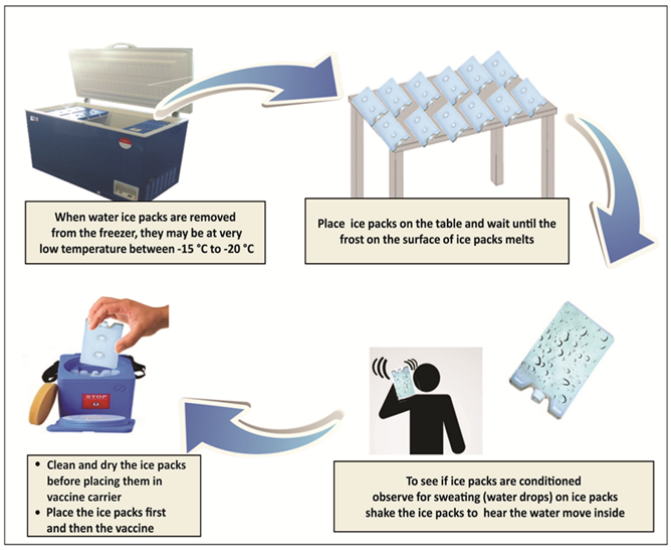
To ensure efficacy of the vaccines, proper storage and packing are essential. The following are recommended for vaccine storage:

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

12.6 Conditioning of water ice packs

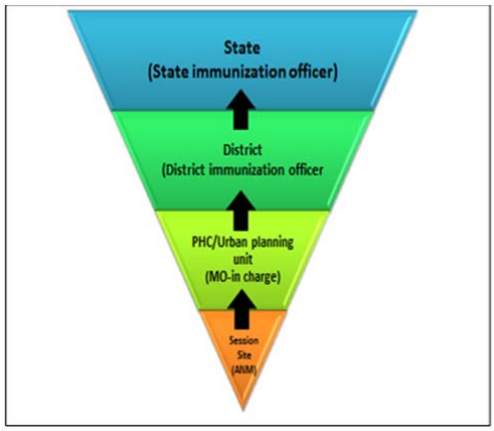
In order to ensure correct storage of vaccines, the following procedures should be followed:

- Ensure that the insulated vaccine carriers are clean before use and at end of the day.
- Use a packing table, and remove ice packs from freezer and place on table to defrost. Packs are ready to use when there are physical signs of thawing; no ice but drops of water on surface, and liquid is observed inside.
- Dry the packs and line the walls of the insulated vaccine carrier with them.
- Place the vaccines inside and ensure that the container is properly closed.



- Allowing ice packs to thaw means that the initial freezing temperature is lost, so the temperature in the insulated carrier does not drop below 0°C.
- Properly conditioned water ice packs constitute the best method to maintain the temperature of the insulated carriers and cold boxes.
- There should be sufficient ice packs to ensure that the vaccines are totally surrounded during transportation.

12.7 Recording and reporting



- Recording and reporting of vaccination during Mission Indradhanush rounds will be done in the attached formats on a daily basis to the next higher level, i.e., ANM will report to the block PHC in the tally sheet for Mission Indradhanush (Annexure 13a & 13 b), block PHC will report to the district, and so on (Figure 3).
- Vaccination will also be reported through the existing HMIS and mother and child tracking system (MCTS) portals. Blocks will compile ANM reports (Annexure 14a & 14b) and districts will compile block reports (Annexure 15a & 15b) and submit to the state (Annexure 16a & 16b).
- Critical indicators that will be derived from these reports are:
    - total beneficiaries immunized
    - total children fully immunized
    - total children completely immunized
    - total beneficiaries vaccinated antigen-wise
    - total children vaccinated for first time
- The routine immunization sessions will be held as planned but coverage data of these sessions will not be included in the Mission Indradhanush coverage report. However, at the end of month, the Mission Indradhanush round coverage data and routine immunization data will be entered together in the HMIS.

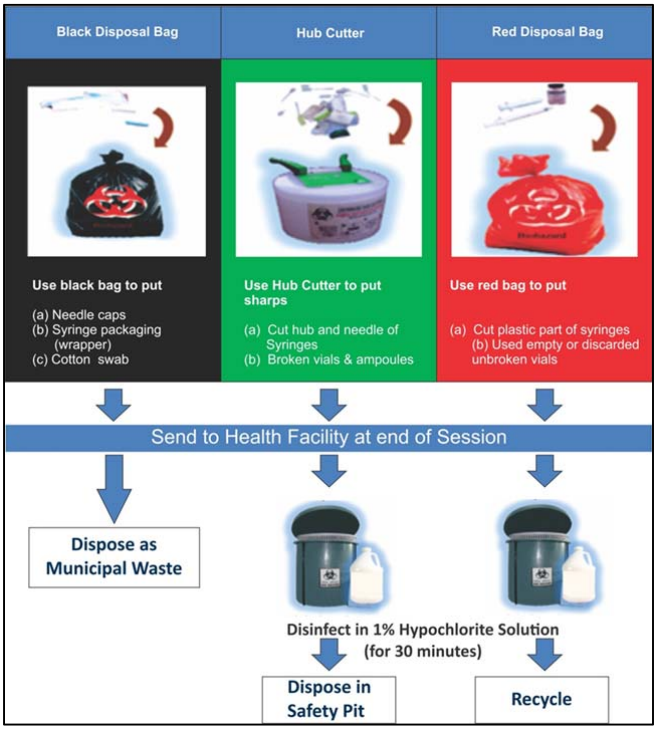
12.8 Communication materials

It is important to revise and distribute IEC materials for creating awareness among the community and caregivers before the Indradhanush rounds. The GoI will share prototypes of IEC materials with all states. The states can adapt these IEC materials as per their requirements.

12.9 Waste disposal

Keeping in harmony with the "*Swaach 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.



12.10 Launch of Mission Indradhanush

Mission Indradhanush provides states with an opportunity to reach the unvaccinated and partially vaccinated children and pregnant women and improve the full immunization status. A well-publicized launch ceremony for the Mission should be planned to improve general awareness about the UIP, with a focus on unreached/poorly reached areas as per the criteria described earlier.

Successful launch of the Mission will include mass media components as well as one-to-one interpersonal contact with beneficiaries to openly respond to queries. To be able to respond comprehensively, other related government departments, local media and NGOs should be briefed and brought on board, so that they may also spread the message and motivate the community to benefit from immunization. The state and district task forces on immunization should steer the planning, coordination, implementation and monitoring of the programme.

Recording and reporting formats and communication materials should be prepared in local languages and distributed well in advance to target audiences. Failures in communication commonly occur because the disseminated materials do not reach the intended targets and/or the information is not appropriate for the intended audience.

ROLE OF PARTNER AGENCIES

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

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 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.
- Track the progress and implementation of the Indradhanush round.
- 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.
- UNICEF will work collaboratively with Immunization Technical Support Unit (ITSU) to develop the dissemination plan for 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.

Rotary International

- Advocacy at state and district levels for routine immunization strengthening, specifically for Indradhanush.
- Supporting the mass awareness campaign through intensified IEC activities and community mobilization interventions.

Lead partners for call to action (RMNCH+A)

- The RMNCH+A state lead partners will assist with implementation of strategies to strengthen the 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.

MONITORING AND EVALUATION

A massive framework has been put in place for rigorous monitoring of one of the largest immunization programmes of the world. Oversight of the implementation activities is crucial at all levels. Supervision should focus on bringing the gaps identified through the state and district preparedness assessment checklists.

"Hon'ble Prime Minister, Shri Narendra Modi, has reviewed Mission Indradhanush under 'PRAGATI' – the ICT-based, multi-modal platform for Pro-Active Governance and Timely Implementation" with Chief Secretaries on 17 February 2016. During the session, he emphasized the need for an organized and aggressive action plan to cover all children for immunization in a specific time-frame.

Critical information on preparedness, 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. Information generated from concurrent monitoring will be utilized at local level during evening debriefing meetings at block and district level to ensure midcourse corrective actions. Data generated from the monitoring formats will be collated in a data tool to generate key indicators that will be shared at all levels with the government.

14.1 Monitoring of operations

The Mission Indradhanush rounds will be intensively monitored in the highest priority areas by officials from the national, state and district levels. Using the 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 deployed to the 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.

Mission Indradhanush Session monitoring indicators

This captures information on vaccine supply and the availability of logistics, functioning of alternate vaccine delivery (AVD) system, injection practices of ANMs, injection safety and

waste disposal, record keeping and inter-personal communication of service providers. The following indicators will be monitored:

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

Mission Indradhanush House-to-house monitoring indicators

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

State /District Immunization Officer

- **Have we made any progress towards expanding our microplans after Phase I and Phase II Mission Indradhanush rounds?**
- **Have all additional sessions planned during Mission Indradhanush (phase I & II) been included in the regular routine immunization microplans in district/blocks?**
- **If yes, have the districts projected their funding requirement accordingly in their project implementation plans (ASHA incentive, AVD, any district specific activity proposed with justification)?**

State/District Immunization Officer

Prior to next phase of Mission Indradhanush

Critical Microplan Review:

- **Has the district assigned priority blocks to senior officers?**
- **Have all areas with vacant sub-centers been included?**
- **Have all areas where no routine immunization sessions planned due to staff on leave/deputation been included?**
- **Are all Polio HRAs with no routine immunization service delivery included?**
- **Areas where VPD outbreaks reported;**
- **Have all hard-to reach areas/areas that are part of routine immunization sessions but with poor mobilization included?**
- **Have areas where routine immunization monitoring shows gaps included?**
- **How many ANMs have been planned to move to other sub center within the same block or to sub centers outside the block but in the same districts?**
- **Have they been informed about their TA/DA support as per state rules?**
- **In the areas where Mission Indradhanush sessions 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 material for next phase of Mission Indradhanush?**
- **Has the district made a plan for timely funds transfer to mobilizers?**

14.2 Adverse Events Following Immunization (AEFI)

Any community's perception and acceptance of immunization rests on its safety. Any AEFI should therefore be reported, investigated and responded to promptly and adequately as per existing guidelines. All staff should familiarize themselves with these guidelines and reporting formats. The AEFI management centres will have to be identified with contact details mentioned in microplans.

14.3 Monitoring of communication interventions

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

- status of all planned IEC/BCC activities mentioned in the state/district communication plan
- progress of various IEC/BCC activities at a particular time and at a particular implementation level
- status of capacity-building activities as per the training plan

- status of dissemination (achieved against planned) and stock position of IEC material at various levels – state, district, block
- status of planned initiatives related to advocacy, coordination, convergence, etc.

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

14.4 Evaluation methodology

A new cross-sectional survey called Integrated Child Health and Immunization Survey (INCHIS) was designed to obtain nationally representative data on immunization coverage and child health during phases I and II of Mission Indradhanush. This survey periodically collected data at a national level to measure progress related to immunization coverage, child health and its system determinants. Using an internationally established sampling methodology, information obtained from selected states has been used to evaluate the impact of Mission Indradhanush.

KEY POINTS FOR SUCCESSFUL IMPLEMENTATION OF MISSION INDRADHANUSH PHASE III

An equity-based programme, Mission Indradhanush launched in 2015, builds on polio strategies, tools, techniques and manpower to focus specific attention on identified high-risk areas with traditionally low coverage, such as slums, and among nomadic populations and migrant families living in brick kilns and construction sites. The mission also targets the 400,000 high risk areas identified in the polio programme as well as other underserved areas where there are insufficient health services (gaps or lack in vaccinators, etc.), migrant populations, recent measles/diphtheria outbreaks or high dropout rates. It uses the special strategies developed by the polio teams to access these high risk, hard-to-reach and underserved communities.

Government ownership, partnerships and accountability framework

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

Microplanning for Mission Indradhanush

- Detailed district and block microplanning was critical to effective interruption of polio transmission in India. During campaigns, vaccinators used microplans to track vaccination activities in each community, and review by district task forces determined which children were missed and corrective actions taken as part of the accountability and supervisory system.
- Certain “high-risk” areas have been especially difficult to immunize – barriers due to geography, poverty, internal mobility/migration, lack of education, variety of languages cultural diversity and distrust of the government, as well as sheer population density have required creative and persistent efforts. Mission Indradhanush brought in communities that previously had only been reached for polio vaccination but with limited access to RI services. Microplanning for Mission

Indradhanush focused on improving coverage and addressing equity issues in access to immunization.

- Additional immunization sites planned under Mission Indradhanush are being included into the government system's Routine Immunization microplans with support from the WHO & UNICEF polio network to ensure completeness of routine immunization service reach.

Head count survey and due list preparation

- Head count process to develop session specific due-list based on head count should be initiated well in advance, and pre-round validation of head survey should be done for improving coverage. There is a need of regular orientation and supervision of frontline workers for doing head count survey, due list updation and mobilization of children.

Capacity building of frontline workers

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

Supervision of activities

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

Vaccine and cold chain management

- Urgent attention is needed to improve vaccine upkeep to ensure conditioning of ice packs, maintenance of distribution register, implementation of open vials policy and its records, and adherence to AVD plan. Focus on cold chain management training.

Social mobilization

- Social mobilization was an issue during first two phases; most of the states did not prepared IEC materials. However, as a result of financial clarity and regular follow ups from national level, significant improvement was observed in most of the states.
- IEC is an important factor in creating awareness in community about the importance of immunization. Therefore, IEC activities should be improved.

- PRI members, ration dealers and local influencers' involvement should be strengthened.

- Need of standardization of IEC material is required.
- Concept of mothers' meeting, Nukkad Natak, videos in the community, etc., should be strengthened.

Timing

- Special catch up rounds should be planned in a way to ensure better coverage of migratory populations and HRG sites.
- In Mission Indradhanush, day should be fixed and not the date. We should plan from a day in the week rather than date in the month.

Financial issues

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

Data management

- Newly designed tally sheet will help in reporting as well as tracking beneficiaries during all rounds.
- Ensure completeness and quality of data transmission an issue.

ANNEXURES

Annexure 1. Mission Indradhanush Phase III, 216 High Focus Districts

STATE	DISTRICTS		
ANDHRA PRADESH (4 districts)	EAST GODAVARI	GUNTUR	KRISHNA
	KURNOOL		
ARUNACHAL PRADESH (5 districts)	CHANGLONG	EAST KAMENG	LOWER DIBANG VALLEY
	LOHIT	LOWER SUBANSIRI	
ASSAM (12 districts)	BARPETA	BONGAIGAON	DARRANG
	DHUBRI	GOALPARA	GOLAGHAT
	HAILAKANDI	KARIMGANJ	MARIGAON
	NAGAON	SONITPUR	KOKRAJHAR
BIHAR (19 districts)	ARARIA	BEGUSARAI	CHAMPARAN EAST
	CHAMPARAN WEST	DARBHANGA	GAYA
	JAMUI	KATIHAR	KISHANGANJ
	MUZAFFARPUR	SARAN	SAHARSA
	SAMASTIPUR	SITAMARHI	BHOJPUR
	SUPAUL	GOPALGAANJ	NAWADA
	LAKHISARAI		
CHHATTISGARH (4 districts)	JASHPUR	BIJAAPUR	RAIPUR
	SARGUJA		
DELHI (2 districts)	NORTH-EAST	NORTH-WEST	
GUJARAT (12 districts)	AHMEDABAD	AHMEDABD CORP.	BANASKANTHA
	DAHOD	DANGS	KUTCH
	PANCHMAHALS	SABARKANTHA	VALSAD
	BHAVNAGAR	JAMNAGAR	JUNAGADH
HARYANA (6 districts)	FARIDABAD	GURGAON	MEWAT
	PALWAL	PANIPAT	REWARI
JAMMU & KASHMIR (5 districts)	DODA	KISHTWAR	PUNCH
	RAJAURI	RAMBAN	
JHARKHAND (6 districts)	DEOGHAR	DHANBAD	GIRIDIH
	GODDA	PAKUR	SAHIBGANJ
KARNATAKA (6 districts)	BANGALORE (U)	BELLARY	GULBARGA
	KOPPAL	RAICHUR	YADGIR
KERALA (2 districts)	PALAKKAD	MALAPPURAM	
MADHYA PRADESH (13 districts)	ALIRAJPUR	ASHOKNAGAR	CHHATARPUR
	DAMOH	JHABUA	PANNA
	RAISEN	REWA	SAGAR
	SATANA	TIKAMGARH	UMARIYA
	VIDISHA		
MAHARASHTRA (12 districts)	AHMEDNAGAR	AURANGABAD	BEED
	DHULE	HINGOLI	JALGAON
	NANDED	NASIK	PALGARH
	PARBHANI	SOLAPUR	THANE
MANIPUR (4 districts)	CHURACHNADPUR	SENAPATI	TAMENGLONG
	UKHRUL		
MEGHALAYA (3 districts)	EAST KHASI HILLS	WEST GARO HILLS	WEST KHASI HILLS
MIZORAM (4 districts)	LAWNGTLAI	LUNGLEI	MAMIT
	SAIHA		

STATE	DISTRICTS		
NAGALAND (6 districts)	DIMAPUR	KIPHIRE	KOHIMA
	MON	TUENSANG	WOKHA
ODISHA (3 districts)	GAJAPATI	KHURDA	RAYAGADA
PUNJAB (3 districts)	GURDASPUR	LUDHIANA	MUKTSAR
RAJASTHAN (12 districts)	ALWAR	BARMER	BUNDI
	CHITTAURGARH	DHAULPUR	JAIPUR
	JODHPUR	KARAULI	NAGAUR
	PRATAPGARH	SAWAI MADHOPUR	TONK
TAMIL NADU (1 district)	COIMBATORE		
TELANGANA (2 districts)	ADILABAD	HYDERABAD	
TRIPURA (3 districts)	DHALAI	TRIPURA NORTH	TRIPURA WEST
UTTAR PRADESH (55 districts)	AGRA	ALIGARH	ALLAHABAD
	AMETHI	AMROHA	AURAIYA
	AZAMGARH	BADAUN	BADOHI
	BAHRAICH	BALLIA	BALRAMPUR
	BANDA	BARABANKI	BAREILLY
	BULANDSHAHAR	CHITRAKOOT	ETAH
	ETAWAH	FATEHPUR	FARRUKHABAD
	FEROZABAD	GHAZIABAD	GONDA
	GORAKHPUR	HAPUR	HATHRAS
	HARDOI	JAUNPUR	KANNAUJ
	KASGANJ	KAUSHAMBI	KANPUR DEHAT
	KUSHINAGAR	KHERI	LALITPUR
	MAINPURI	MAHARAJGANJ	MATHURA
	MEERUT	MIRZAPUR	MORADABAD
	MUZAFFARNAGAR	PILIBHIT	RAMPUR
	SHAHJAHANPUR	SAMBHAL	SIDDHARTHNAGAR
	SHAMLI	SONBHADRA	SITAPUR
	SULTANPUR	SRAWASTI	VARANASI
	UNNAO		
UTTARAKHAND (1 district)	HARDWAR		
WEST BENGAL (11 districts)	24-PARGANAS NORTH	24-PARGANAS SOUTH	BARDHAMAN
	BIRBHUM	MURSHIDABAD	UTTAR DINAJPUR
	PURBA MEDINIPUR	COOCH BEHAR	JALPAIGURI
	ALIPURDUAR	BANKURA	

Annexure 2. National Immunization Schedule (NIS) for infants, children and pregnant women

Vaccine	Due age	Max age	Dose	Diluent	Route	Site
For Pregnant Women						
TT-1	**Early in pregnancy**	**Give as early as possible in pregnancy**	**0.5 ml**	**NO**	**Intra-muscular**	**Upper Arm**
TT-2*	**4 weeks after TT-1***		**0.5 ml**	**NO**	**Intra-muscular**	**Upper Arm**
TT- Booster	**If received 2 TT doses in a pregnancy within the last 3 years***		**0.5 ml**	**NO**	**Intra-muscular**	**Upper Arm**
For Infants						
BCG	At birth	till one year of age	**(0.05 ml until 1 month)** 0.1ml Beyond age 1 month	YES **Manufacturer supplied diluent** (Sodium chloride)	Intra-dermal	Upper Arm - LEFT
Hepatitis B - Birth dose	At birth	within 24 hours	0.5 ml	NO	Intra-muscular	Antero-lateral side of mid-thigh - LEFT
OPV-0	At birth	within the first 15 days	2 drops	-	Oral	Oral
OPV 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	till 5 years of age	2 drops	-	Oral	Oral
DPT 1, 2 & 3	**DPT 1, 2 & 3 are replaced by Pentavalent 1, 2 & 3**					
Hepatitis B 1, 2 & 3	**Hepatitis B 1, 2 & 3 are replaced by Pentavalent 1, 2 & 3**					
Pentavalent 1, 2 & 3[†] (Diphtheria+ Pertussis + Tetanus + Hepatitis B + Hib)	At 6 weeks, 10 weeks & 14 weeks**	1 year of age	0.5 ml	NO	Intra-muscular	Antero-lateral side of mid-thigh - LEFT
IPV # (Inactivated Polio Vaccine)	At 14 completed weeks	1 year of age	0.5 ml	NO	Intra-muscular	Antero-lateral side of mid-thigh - RIGHT
Rotavirus[‡] **(Where applicable)**	At 6 weeks, 10 weeks & 14 weeks	1 year of age	5 drops	NO	Oral	Oral

Vaccine	Due age	Max age	Dose	Diluent	Route	Site
Measles/MR 1st dose ##	At 9 completed months-12 months.	5 years of age	0.5 ml	YES **Manufacturer supplied diluent** (Sterile water)	Sub-cutaneous	Upper Arm - RIGHT
Japanese Encephalitis – 1 @ (Where applicable)	At 9 months-12 months @	15 years of age	0.5 ml	YES - **Manufacturer supplied diluent** (Phosphate Buffer Solution)	Sub-cutaneous	Upper Arm - LEFT
Vitamin A (1st dose)	At 9 months	5 years of age	1 ml **(1 lakh IU)**	-	Oral	Oral
For Children						
DPT Booster-1	16-24 months	7 years of age	0.5 ml	NO	Intra-muscular	Antero-lateral side of left mid-thigh
Measles/MR 2nd dose ##	16-24 months	5 years of age	0.5 ml	YES **Manufacturer supplied diluent** (Sterile water)	Sub-cutaneous	Upper Arm - RIGHT
OPV Booster	16-24 months	5 Years	2 drops	NO	Oral	Oral
Japanese Encephalitis – 2 @ (Where applicable)	16-24 months @	till 15 years of age	0.5 ml	YES **Manufacturer supplied diluent** (Phosphate Buffer Solution)	Sub-cutaneous	Upper Arm - LEFT
Vitamin A $ (2nd to 9th dose)	At 16 months. Then, one dose every 6 months	Up to the age of 5 years	2 ml **(2 lakh IU)**	-	Oral	Oral
DPT Booster-2	5-6 years	7 years of age	0.5 ml	NO	Intra-muscular	Upper Arm
TT	10 & 16 years	16 years	0.5 ml	NO	Intra-muscular	Upper Arm

***** Give TT-2 or Booster doses before 36 weeks of pregnancy. However, give these even if more than 36 weeks have passed. Give TT to a woman in labour, if she has not previously received TT. **†** Pentavalent vaccine is introduced in place of DPT and HepB 1, 2 and 3. **‡** Rotavirus vaccine has been introduced in initially 4 states – Andhra Pradesh, Haryana, Himachal Pradesh and Odisha. **# IPV – fractional dose (0.1ml) intradermal at ages 6weeks and 14 weeks introduced in select states. ##** MR vaccine has been recommended and approved for introduction in place of measles vaccine in the UIP schedule. @ JE Vaccine has been introduced in select endemic districts. **If first dose delayed beyond 12 months ensure minimum 3 months gap between 2 JE doses. $** The 2nd to 9th doses of Vitamin A can be administered to children 1-5 years old during biannual rounds, in collaboration with ICDS.

Annexure 3. Agenda for state workshop for Mission Indradhanush

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

Duration: 1 day

Time	Session	Facilitator
	Registration	
45 minutes	Welcome and introduction	
	Introduction to Mission Indradhanush	State Immunization Officer
	Remarks by partners	
	Remarks by Principal Secretary, Health	
30 minutes	Overview of immunization programme at national and state level	WHO India
	Tea	
1 hour	Operationalization of Mission Indradhanush • RI microplanning • Conducting head count and preparing due lists	WHO India
30 minutes	Organizing and conducting trainings	State Immunization Officer/WHO India
15 minutes	Monitoring and supervision	WHO India
15 minutes	**Discussion**	
	Lunch	
30 minutes	Exercise on reporting and recording	WHO India & ITSU
30 minutes	IEC, social mobilization and media interaction	UNICEF & ITSU
30 minutes	Adverse events following immunization	WHO India & ITSU
15 minutes	**Discussion**	
	Tea	
45 minutes	Financial guidelines for Mission Indradhanush	State Immunization Officer
15 minutes	Way forward for Mission Indradhanush – Timeline of activities and support available	Mission Director
	Closing remarks	

Annexure 4a. Agenda for district workshop on Mission Indradhanush for medical officers

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

Duration: 1 day

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

Annexure 4b. Agenda for district orientation of district and block level programme/accounts managers on financial guidelines for Mission Indradhanush

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

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

Time: 1 hour

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

Annexure 4c. Agenda for district workshop on Mission Indradhanush for data handlers

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

Training material: Reporting formats for Mission Indradhanush

Duration: Half day

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

Annexure 4d. Agenda for district workshop on Mission Indradhanush for vaccine and cold chain handlers

Participants: One cold chain handler from each cold chain point

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

Duration: Half day

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

Annexure 5. Agenda for block/urban area training of health workers for Mission Indradhanush

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

Annexure 6. Agenda for block/urban area training of mobilizers(ASHAs/AWWs/link workers) for Mission Indradhanush

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

Annexure 7. Financial norms under Mission Indradhanush

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

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

The following norms remain the same as earlier:

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

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

Reflecting change in mode of payment from the existing norms:

Activity	Existing Norms	For Mission Indradhanush
Vaccinators and mobilizers		
Line listing of households done twice a year at six-month interval	Rs 100 for ASHAs	For 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 100.
Preparation of due list of children to be immunized to be updated on a monthly basis	Rs 100 for ASHAs	For 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 100.
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.

Annexure 8. Mission Indradhanush sub-centre planning (Format 1)

For ANM

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

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

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

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

Signature of ANM

Annexure 9. Mission Indradhanush: Block/urban area planning (Format 2)

For Block/urban planning unit

(Compile information from Planning Format 1)

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

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

Annexure 10. ANM micro plan roster for Mission Indradhanush (Format 3)

Round I/II/III/IV **For ANM**

(One format for each ANM in the district)

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

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

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

	Description of areas selected for Indradhanush session (exclude Sundays and other govt. holidays)						
	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
Village/ urban area							
Sub-centre							
Block & planning unit							
Reasons for area selection*							
Session site address & timing							
Name & Tel no of mobilizer							
Designation of mobilizer							
Name & Tel no of AVD person							
Name of influencer							
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 11. Mobile team planning for Mission Indradhanush **For Block**

(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 12. Mission Indradhanush: District planning

For DIO

District: **Name of DIO:**

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

Signature of DIO

Annexure 13a: Tally sheet for Mission Indradhanush session

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

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

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

S. No	Name of beneficiary	Father/ husband name	Age	Sex	Whether child vaccinated for the first time in life	Pregnant Women			CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY																		Full immunization achieved (Y/N)	CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY					Complete immunization achieved (Y/N)	DPT-B (5-6 years)
						TT-1	TT-2	TT- B	BCG	OPV-1	*DPT-1	*Hep B-1	Penta 1	RVV-1	OPV -2	*DPT- 2	Hep B-2	Penta 2	RVV-2	OPV-3	*DPT-3	Hep B-3	Penta-3	RVV-3	IPV	Measles1	JE-1	Vit A-1		OPV-B	DPT- B	Measles2	JE-2	Vit A-2		
Total																																			

FULL IMUNIZATION ACHIEVED		
	Male	Female
9-11 months		
12-23 months		

Children vaccinated for the first time in life	
0-11 months	
12-23 months	

Total Children vaccinated	
AD Syringes 0.1ml used	
AD Syringes 0.5ml used	
5ml Reconstitution Syringes used	
Total no. of ORS distributed	
Total no. of Zinc Tablets distributed	

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

Signature of ANM

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 13b: Tally sheet for Mission Indradhanush session for 8 states (Odisha, Maharashtra, Tamil Nadu, Telangana, Karnataka, Kerala, Puducherry & Andhra Pradesh)

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

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

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

S. No	Name of beneficiary	Father/ husband name	Age	Sex	Whether child vaccinated for the first time in life	Pregnant Women			CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY																		Full immunization achieved (Y/N)	CROSS THE BOX FOR EACH VACCINE GIVEN TO THE BENEFICIARY					Complete immunization achieved (Y/N)	DPT-B (5-6 years)
						TT-1	TT-2	TT- B	BCG	OPV-1	*DPT-1	*Hep B-1	Penta 1	RVV-1	IPV-1	OPV -2	*DPT- 2	Hep B-2	Penta 2	RVV-2	OPV-3	*DPT-3	Hep B-3	Penta-3	RVV-3	IPV-2	Measles1	JE-1	Vit A-1		OPV-B	DPT- B	Measles2	JE-2	Vit A-2		
Total																																				

FULL IMUNIZATION ACHIEVED		
	Male	Female
9-11 months		
12-23 months		

Children vaccinated for the first time in life	
0-11 months	
12-23 months	

Total Children vaccinated	
AD Syringes 0.1ml used	
AD Syringes 0.5ml used	
5ml Reconstitution Syringes used	
Total no. of ORS distributed	
Total no. of Zinc Tablets distributed	

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

Signature of ANM

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 14a: Block daily reporting format for Mission Indradhanush **Date of activity:** _____ **For Block**

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

S. No	Name of ANM	Session site address	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																			Full immunization achieved				Record number of vaccinations					Complete immunization achieved	DPT-B(5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
				0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	DPT-1	*Hep B-1	Penta 1	RVV1	OPV 2	DPT-2	*Hep B-2	Penta 2	RVV 2	OPV3	DPT-3	*Hep B-3	Penta 3	RVV 3	IPV	Measles1	JE-1	Vit A-1	Male	Female	Male	Female	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
																												9 - 11 months		12 - 23 months										
Grand Total																																								

Signature of I/C Block Medical Officer

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 14b: Block daily reporting format for Mission Indradhanush for 8 states (Odisha, Maharashtra, Tamil Nadu, Telangana, Karnataka, Kerala, Puducherry and Andhra Pradesh) Date of activity: _____ For Block

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

S. No	Name of ANM	Session site address	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																				Full immunization achieved				Record number of vaccinations					Complete immunization achieved	DPT-B(5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
				0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	DPT-1	*Hep B-1	Penta 1	RVV1	IPV-1	OPV 2	DPT-2	*Hep B-2	Penta 2	RVV 2	OPV3	DPT-3	*Hep B-3	Penta 3	RVV 3	IPV-2	Measles1	JE-1	Vit A-1	Male (9 - 11 months)	Female (9 - 11 months)	Male (12 - 23 months)	Female (12 - 23 months)	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
Grand Total																																									

Signature of I/C Block Medical Officer

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 15a: District daily reporting format for Mission Indradhanush **Date of activity:** _____ **For District**

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

S. No	Block name	No of sessions held	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																			Full immunization achieved				Record number of vaccinations					Complete immunization achieved	DPT-B(5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
				0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	DPT-1	*Hep B-1	Penta 1	RVV1	OPV 2	DPT-2	*Hep B-2	Penta 2	RVV 2	OPV3	DPT-3	*Hep B-3	Penta 3	RVV 3	IPV	Measles1	JE-1	Vit A-1	Male	Female	Male	Female	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
																												9 - 11 months		12 - 23 months										
Grand Total																																								

Signature of Chief Medical Officer

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 15b: District daily reporting format for Mission Indradhanush for 8 states (Odisha, Maharashtra, Tamil Nadu, Telangana, Karnataka, Kerala, Puducherry & Andhra Pradesh)

Date of activity: _____ **For District**

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

S. No	Block name	No of sessions held	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																			Full immunization achieved				Record number of vaccinations					Complete immunization achieved	DPT-B(5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
				0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	DPT-1	*Hep B-1	Penta 1	RVV1	IPV-1	OPV 2	DPT-2	*Hep B-2	Penta 2	RVV 2	OPV3	DPT-3	*Hep B-3	Penta 3	RVV 3	IPV-2	Measles1	JE-1	Vit A-1	Male (9 - 11 months)	Female (9 - 11 months)	Male (12 - 23 months)	Female (12 - 23 months)	OPV-B	DPT - B	Measles2	JE-2	Vit A-2				
Grand Total																																									

Signature of Chief Medical Officer

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 16a: State daily reporting format for Mission Indradhanush

Date of activity_____ **For State**

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

S. No	District name	No of sessions held	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																			Full immunization achieved				Record number of vaccinations					Complete immunization achieved	DPT-B(5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
				0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	DPT-1	*Hep B-1	Penta 1	RVV1	OPV 2	DPT-2	*Hep B-2	Penta 2	RVV 2	OPV3	DPT-3	*Hep B-3	Penta 3	RVV 3	IPV	Measles1	JE-1	Vit A-1	Male	Female	Male	Female	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
																												9 - 11 months		12 - 23 months										
Grand Total																																								

Signature of State Immunization Officer

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 16b: State daily reporting format for Mission Indradhanush for 8 states (Odisha, Maharashtra, Tamil Nadu,Telangana, Karnataka, Kerala, Puducherry & Andhra Pradesh) **Date of activity_____** **For State**

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

S. No	District name	No of sessions held	No. of children vaccinated	No. of children vaccinated for the first time in life		Pregnant female			Record number of vaccinations for each antigen																				Full immunization achieved				Record number of vaccinations					Complete immunization achieved	DPT-B(5-6 years)	No. of ORS distributed	No. of Zinc tablets distributed
				0 - 11 mo	12 - 23 mo	TT-1	TT-2	TT- B	BCG	OPV1	DPT-1	*Hep B-1	Penta 1	RVV1	IPV-1	OPV 2	DPT-2	*Hep B-2	Penta 2	RVV 2	OPV3	DPT-3	*Hep B-3	Penta 3	RVV 3	IPV-2	Measles1	JE-1	Vit A-1	Male	Female	Male	Female	OPV-B	DPT- B	Measles2	JE-2	Vit A-2				
																													9 - 11 months		12 - 23 months										
Grand Total																																									

Signature of State Immunization Officer

- Children less than 1 year should not be given DPT1/Hep B-1, start schedule with pentavalent vaccine only.
- Children who have already received Hep B-1 should be given Hep B-2 & Hep B-3 dose, only if the child coming to session site is under one year of age. Hep-B is not to be given beyond one year of age.
- Children who have already received DPT-1 should be given subsequent doses within or over one year of age as per recommended guidelines.
- 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.
- 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.

Annexure 17. Daily vaccine and diluents utilization reporting format

For Vaccine and Cold Chain Handlers

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

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

Signature of MOIC

Name and signature of cold chain handler