Internship Training

in

National Health Systems Resource Centre, New Delhi

(February 1-April 30, 2015)

MONITORING OF FIRST DRIVE OF MISSION INDRADHANUSH IN DEOGHAR DISTRICT OF JHARKHAND

By

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Enrolment Number-PG/13/024

Under the Guidance of

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Post-Graduate Diploma in Hospital & Health Management
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Technical Support Institution with National Rural Health Mission
Ministry of Health & Family Welfare Government of India

(Completion of Dissertation from NHSRC, New Delhi)

The certificate is awarded to

Ms. Hansa Lala

In recognition of having successfully completed her Internship in the department of

NHSRC, New Delhi

and has successfully completed her Project on

MONITORING OF FIRST DRIVE OF MISSION INDRADHANUSH IN DEOGHAR DISTRICT OF JHARKHAND

13th May, 2015

Quality Improvement Division, NHM Jharkhand

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish her all the best for future endeavors

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Hansa Lala**, a student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **National Health Systems Resource Centre(NHSRC), New Delhi** from **09/02/2015 to 09/05/2015**

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dr. A K. Agarwal
Dean, Academics and Student Affairs
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CERTIFICATE OF APPROVAL

The following dissertation titled **"A Report on monitoring of first drive of Mission Indradhanush in Deoghar district of Jharkhand"** at **"National Health Systems Resource Centre, New Delhi"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Prof Pitty Kaul	
Dr Preetha RS	
Dr Dhananjay.	

Certificate from Dissertation Advisory Committee

This is to certify that **Ms. Hansa Lala,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"Monitoring of first drive of Mission Indradhanush in Deoghar District of Jharkhand" at "NATIONAL HEALTH SYSTEMS RESOURCE CENTRE, NEW DELHI"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"A Report on monitoring of first drive of Mission Indradhanush in Deoghar district of Jharkhand"** and submitted by **Ms. Hansa Lala, Enrollment No- PG/13/024** under the supervision of Dr. Vinay Tripathi,(Associate Professor) for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 09/05/2015 to 09/05/2015 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Hansalala.

Signature

FEEDBACK FORM

Name of the Student: Hansa Lala

Dissertation Organization: NIHSRC, New Delhi

Area of Dissertation: Monitoring of Mission Indradhanush first drive in Deoghar District, Jharkhand.

Attendance: 100%

Objectives achieved: Yes

Deliverables: Feedback and evaluation done properly

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Suggestions for Improvement:

Signature of the Officer-in-Charge/ Organization Mentor (Dissertation)

Date: 15/5/2015
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ACKNOWLEDGEMENT

"*Any accomplishment requires the grace of god as well as help and good wishes of many people and this work is not different*"

This perspicuous piece of acknowledgement is an opportunity and humble privilege for me to express my deepest sense of gratitude and indebtness to those people without whose help, assistance and guidance, the present work would have been impossible.

I would like to thank my mentor Dr. Vinay Tripathi , Dean (Dr. A.K Agarwal) and the Institute, IIHMR, Dwarka for extending their support, guidance throughout the internship period.

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ABBREVIATIONS

ADHS-Assistant Director Health Services

AEFI-Adverse Reaction post Immunization

ANM- Auxiliary Nurse midwife

ASHA-Accredited Social Health Activist

AWW- Anganwadi worker

BCC-Behaviour Change Communication

BCG-Bacillus Calmette Guerin

BMOIC-Block Medical Officer In-charge

CBHI-Central Bureau of Health Intelligence

CES-Coverage Evaluation Survey

CHC-Community Health Centre

CINI-Child in Need Institute

CMO-Chief Medical Officer

DIO-District Immunization Officer

DLHS-District Level Household Survey

DRCHO-District Reproductive and child health officer

DM-District Magistrate

DPT- Diphtheria, Pertusis, Tetanus

DUDA-District Urban Development Agency

EPI-Expanded Programme on Immunization

HFD-High focus District

ICDS-Integrated Child Development Scheme

IEC-Information, education, communication

IMR-Infant Mortality Rate

MOH&FW-Ministry of Health and Family Welfare

MI-Mission Indradhanush

NFHS-National Family Health Survey

NGO-Non Governmental Organization

NVP-National Vaccine Policy

PHC-Primary Health Centre

RCH-Reproductive and Child health

RI-Routine Immunization

SMO-Surveillance Medical Officer

SUDA-State Urban Development Agency

UIP-Universal Immunization Programme

UNICEF-United Nation Children's Fund

USAID-United States Agency for International Fund

VPD-Vaccine Preventable Disease

WHO-World Health Organization

ORGANIZATIONAL PROFILE

National Health Systems Resource Centre (NHSRC) has been set up under the National Rural Health Mission (NRHM) of Government of India to serve as an apex body for technical assistance in 2007 headed by Dr Sanjiv Kumar (Executive Director). The National Health Systems Resource Centre's mandate is to assist in policy and strategy development in the provision and mobilisation of technical assistance to the states and in capacity building for the Ministry of Health and Family Welfare (MoHFW) at the centre and in the states. The goal of this organization is to improve health outcomes by facilitating governance reform, health systems innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models. Vision of the organization is to facilitate the attainment of universal access to equitable, affordable, and quality healthcare which is accountable and responsive to the needs of the people. The NHSRC has a regional office in the north-east region of India. The North East Regional Resource Centre (NE RRC) has functional autonomy and implements a similar range of activities.

The NHSRC currently consists of eight divisions – Community Processes, Public Health Planning, Human Resources for Health, Quality Improvement in Healthcare, Healthcare Financing, Healthcare Technology, Health Informatics and Public Health Administration.

It has a 21 member Governing Board, chaired by the Secretary, MoHFW, Government of India with the Mission Director, NRHM as the Vice Chairperson of the board and the Chairperson of its Executive Committee. Of the 21 members, 11 are ex-officio senior health administrators, four from the states. Ten are public health experts from academics and civil society. The Executive Director, NHSRC is the Member Secretary of both the board and the Executive Committee. NHSRC is also a World Health Organisation Collaborating Centre for Priority Medical Devices & Health Technology Policy

Quality Improvement Division

Basically encompasses Quality improvement in Public Health Facilities (District hospitals, Community health centres, Primary health centres).Till 2013 it was the ISO platform that has been built upon and its standards were strengthened with mandatory inclusion of 24 procedures, which are specific to the Public Health. Over 140 facilities, ranging from Primary Healthcare Centers to District Hospitals were assessed against these ISO 9001:2008 plus NHSRC defined Standards. But in December 2013, NHSRC has come up with National Quality Health Standards for District Hospitals which is basically a set of standards and checklists which is used to assess the facilities and score them for certification from Government of India.The main activity areas in this domain are :-

1. Developing Standards and Guidelines
2. Training and capacity building
3. Institutional Frameworks for building, monitoring and certifying for quality
4. Infrastructure Planning
5. Developing Resources and Publications for Quality Assurance
6. Advocacy and Policy

Health Informatics

The various sub-domains of health informatics include Hospital Information System, Human Resource Management Information System, Health Management Information System, Geographical Information System, mobile specific program monitoring system, and mobile health. The main activities includes analysis of HMIS data from states, their interpretation, dissemination of information to states.

Public Health Planning

This practice area is not only important for developing the health plans and programmes responsive to the needs of population, but it is also vital for budgeting and resource allocation in a systematic and equity sensitive manner. Currently they are framing National Health Policy 2015.

Community Process

This area works for the development of training modules, conducting training, capacity building of community participant such as ASHA,VHNSC to achieve the goals of NHM. Some of the guidelines framed by this department are- Guidelines for ASHA and MAS in Urban context, HBNC Operarional guidelines, guidelines for NGO involvement under NHM

Public health Administration

The division is providing technical support to MoHFW in programmatic areas where legal questions are involved. Specific areas of current intervention by NHSRC include:

1. Implementation of Clinical Establishments (Registration & regulation) Act, 2010
2. Development of a Health Rights Act and the Public Health Act
3. Responding to queries relating to legal issues from MoHFW on a number of areas

Health technology and innovation

Division of Healthcare Technology, a WHO Collaborating Centre for Priority Medical Devices & Health Technology Policy supports the following

a. Technical Specifications of Medical Devices procured under National Health Mission
b. Biomedical Equipment Maintenance Program across all levels of public health facilities
c. Identification, assessment and uptake of innovations in National Health Programs
d. Support in Health Technology systems strengthening and providing technical support to Government's agenda on improving cost of technologies, safety profile of products

Public Health Financing

This division basically works for the public health expenditure part by GOI. Helps to support advocacy to increase public health expenditure. The main strategy for achieving this is the availability of free or subsidised services provided by the public sector. A sub-component of this agenda is to ensure access to free drugs and diagnostics through the public health system. Supplementar

INTRODUCTION

HISTORY OF IMMUNIZATION IN INDIA

Our country's National Population Policy 2000 emphasizes on "achievement of universal immunization of children against all vaccines preventable diseases" and has recognized it as one of the National Socio-Demographic Goals for 2010 along with "prevention and control of communicable disease." This is also re-emphasized in the mission document of the National Rural Health Mission (NRHM).

The Expanded Programme on Immunization (EPI) was initiated by the Government of India in 1978 with the objective of reducing morbidity, mortality and disability from six of the major Vaccine Preventable Diseases (VPD) by making vaccination services available to all eligible children free of cost through the public health sector in accordance with Health for All by 2000. The target in EPI was at least 80 per cent coverage in infancy, the vaccination was offered through major hospitals and largely restricted to the urban areas and thus understandably, the coverage remained low. In 1979-80 immunizations against Polio was included under the programme and in 1980-81 Tetanus were introduced to school children. BCG inoculation was initially included under the National Tuberculosis Control Programme in 1962 but was brought under EPI in 1981- 82. Vaccination against Measles was the last one introduced under this programme during 1985-86. The Universal Immunization Programme (UIP) was formulated and introduced in 1985-86 and Vitamin-A supplement was added to this programme in 1990. The stated objectives of UIP are to rapidly increase immunization coverage, improve the quality of services, establish a reliable cold chain system to the health facility level, introduce a district-wise system for monitoring of performance, and achieve self-sufficiency in vaccine production. The Universal Immunization Programme was started in India with the aim of achieving at least 85% coverage of primary immunization of infants, i.e. with three doses of DPT and OPV, one dose of BCG and one dose of measles by the year 1990[1].UIP become a part of Child Survival and safe motherhood Programme in 1992 and since 1997 immunization activity have been important component of National Reproductive and child health Programme and currently a key area under National Health Mission(NHM).In addition to the ongoing immunization Programme,the Pulse Polio Immunization campaign was initiated in 1995 to eradicate Poliomyelitis from India.Under UIP, government is covering immunization to prevent seven preventable diseases, namely Diptheria, Pertussis, Tetanus, childhood TB, Polio, Measles, Hepatitis B, JE(in selected high burden districts), Pentavalent (in selected states). The objectives and major focus in UIP were:

(i) Rapidly increasing immunization coverage and reduction of mortality and morbidity due to six vaccine preventable diseases (VPDs)

(ii) Improve the quality of service*(iii)* Establish a reliable cold chain system till health facility level

(iv) Phased implementation - all districts to be covered by 1989-1990

(v)Introduce a district-wise system for monitoring and evaluation, and

(vi)Achieve self-sufficiency in vaccine production and manufacturing of cold chain equipment

The UIP started in 31 districts in 1985 with plan of scale up to additional districts. The coverage target was all pregnant women and 85 per cent of all infants against six VPDs by March 1990. With effect from 1990-1991, the vaccination programme became universalized in geographical coverage and the target of UIP was increased to cover 100 per cent of the infants[2]

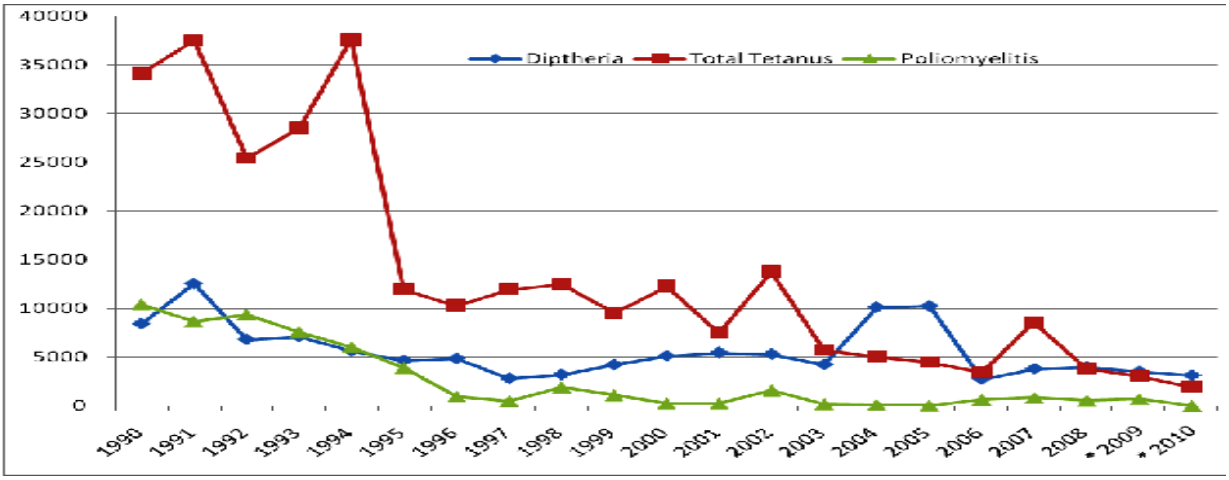
A specific Immunization Strengthening Project (ISP) was designed to run from 2000-2003, which included three main components (polio eradication, strengthening routine immunization, and strategic framework for development).As per Coverage Evaluation Survey 2009,89.8%vaccination in India is provided through Public sector ,while private sector contribute only 8.7%[3.] Ministry of Health and Family Welfare also revised the National Vaccine Policy(NVP) in 2011. The goal of this vaccine policy is to guide decision making in order to develop a long term plan to strengthen the UIP. To evaluate immunization coverage, country conducts period population based surveys. The year 2012-2013 was declared as 'Year of intensification of Routine Immunization (IRI) in India. There was increased focus on improving coverage in identified 239 poor performing districts in India. The government intends to focus attention and priority on conducting immunization week in these states and districts, conducting more regular review and monitoring and supervisions, improving cold chain status, and improving IEC efforts for increasing coverage for all the antigens[4]. These include National Family Health Survey (NFHS), District Level Health Survey (DLHS), Annual Health Survey (AHS) and UNICEF Coverage Evaluation Survey (CES).

IMPACT OF UIP IN YEARS:

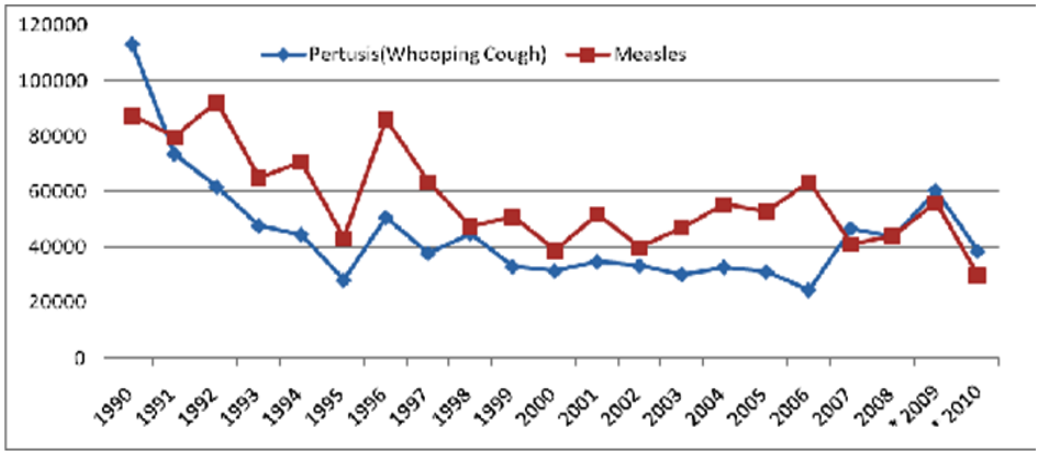
Eradication of Small Pox in 1997and Polio in 2013 from country

Diseases	1980	1985	1990	1995	2000	2005	2010	2012
Diptheria	39231	15685	8425	2123	5125	10,231	3123	2525
Measles	114036	161216	89612	37494	38835	52454	29808	18668
Pertussis	320109	184368	112416	4073	31431	13955	38493	44154
Polio	18975	22570	10408	3263	265	66	43	0
Neonatal Tetanus	-	-	9313	1783	3287	891	373	588
Total Tetanus	45948	37647	23356	-	8997	3543	1574	2404

Table1; Impact of UIP; Source: WHO vaccine-preventable diseases: monitoring system 2013 global summarY



Graph 1; Source: CBHI



Graph2; Source-CBHI

MISSION INDRADHANUSH

Mission Indradhanush was launched by Ministry of Health and Family welfare on 25th December 2015 to achieve maximum immunization (90%) in India. It is launched as a special drive to strengthen the UIP to vaccinate all unvaccinated and partially vaccinated children which are drop-outs due to one or the other reason. The mission focuses on improvement of immunization coverage from 64% in 2014 to at least 90% in next five years. This will be done by catch up drive. Under Mission Indradhanush , the government has defined 201 high focus Districts across the country which has nearly 50%of unvaccinated children in the country. Four states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh account for 82 of the 201 high focus districts and nearly 25% of the unvaccinated or partially vaccinated children of India.

Rationale for launching MI:

Since 2009-2013, there has been increase in immunization rate from 61% to 65%,suggesting a average increase of 1% increase in every year respectively which is quite low. Therefore to accelerate the process of immunization covering 5% or more children every year, this mission mode has been initiated to achieve target of full immunization by 2020.

AIMS AND OBJECTIVES OF MI

General

The 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 201 high focus districts.

Specific Objective

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

• Generating high demand for immunization services by addressing communication challenges

• Enhancing political, administrative and financial commitment through advocacy with key stakeholders

• Ensuring that the partially immunized and unimmunized children are fully immunized as per national immunization schedule

Areas under focus

Mission Indradhanush will be a nationwide drive, with focus on 201 identified high focus districts.

Key areas reached through Mission Indradhanush will be:

- Areas with vacant sub-centers: No auxiliary nurse midwife (ANM) posted for more than
  three months.
- Villages/areas with three or more consecutive missed routine immunization (RI) sessions:
  ANMs on long leave or other similar reasons.
- High risk areas (HRAs) identified by the polio eradication programme. These include population living in areas such as
  - o Urban slums with migration
  - o Nomadic sites
  - o Brick kilns
  - o Construction sites
  - o Other migrant settlements (fisherman villages, riverine areas with shifting populations)

o Underserved and hard to reach populations (forested and tribal populations, hilly areas

- Areas with low RI coverage, identified through measles outbreaks, cases of diphtheria and neonatal tetanus in last two years.
- Small villages, hamlets, dhanis, purbas, basas (field huts), etc., clubbed with another village for RI sessions and not having independent RI sessions.

STRATEGY FOR MISSION INDRADHANUSH

- Four intensified RI drive
  - Each drive will begin on Monday and will last for upto seven(7)days
- Targeted beneficiaries
  - Children under two years of age and pregnant women
  - However, children above two years of age seeking vaccination at any Indradhanush session will not be denied due vaccines.
- Routine immunization system strengthening:
  - Efforts must be made to include areas identified for Mission Indradhanush in regular RI plans
  - RI sessions on other days of the week
  - Utilize 5th week for covering these areas
  - At least 4 sessions/year

BROAD PLAN FOR MISSION INDRADHANUSH

Two main components of MI:

- Operational Planning
- Communication Planning

Operational Planning

Fixed and outreach sessions	Mobile sessions
Site for vaccination: Urban areas- Urban health posts, PP Centre, Family Welfare centre, Primary schools, Anganwadi Centres, Private Dispensaries, NGO sites **Availability of HR:** Health staffs from CHC/PHC, NGO's, Retired health workers from ESIC,CGHS, Armed Forces, Railways, DUDA, SUDA **Timing:** 9am-4pm **Team:** 1 vaccinator and upto two mobilizers. Additional vaccinator if workload of injection is 60-70	**Should be planned where:** Routine immunization coverage is weak. Areas include-Peri-urban areas, scattered slums, brick kilns, slums, construction sites. Mobile vans can be used as clinics. ICDS may support these mobile clinics through supplementary nutrition.

Planning consideration

Following activities will be critical for the successful implementation of Mission Indradhanush:

- Meticulous planning of immunization sessions at all levels: Plan sessions for identified areas with inadequate reach of immunization programme. 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 corporate).
- 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

COMMUNICATION PLANNING

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; and
- Social mobilization through interpersonal communication, school and youth networks and
  corporates.

Monitoring of communication interventions

- These drives will be monitored by independent agencies including WHO India and UNICEF.
- Besides these agencies, observers from national, state and district level will also monitor the drives intensively. Feedback will be provided to district (DTFI) and state task forces for immunization (STFI), who will ensure corrective actions. The mission will also be closely monitored by Chief Secretary at the state level and Ministry of Health & Family Welfare at the national level.

A) NATIONAL COMMUNICATION PLAN: The communication activities initiated at the national level will focus primarily on mass media channels and their frequency and periodicity. The communication activities will include:

• Launch of Mission Indradhanush
• National media management
• Airing of TV spots on national and regional channels
• Radio jingles on FM and AIR.
• Newspaper advertisements (English and Hindi)
• SMS campaign
• Quarterly newsletter (Catch-up or separate newsletter on Mission Indradhanush)

• Consolidated Progress report
• Monitoring of communication interventions

B) STATE COMMUNICATION PLAN: Communication plan at the state level will include the following five 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

Communication activities at the state level will include the following:

• Development of State communication action plan
• Capacity building of state/district officials on operationalization of communications plan
o IPC Skills training of state officials
o Capacity building of media spokespersons
Mass media
o Airing of TV spots on regional channels
o Radio jingles on local FM
o Newspaper advertisements in state-level newspapers (English and Hindi)
o SMS campaign
• Cross-district visits

c) DISTRICT COMMUNICATION PLAN

Communication activities at the district level will include the following:

• Development of District communication action plan
• ***Capacity building***
o IPC skills training for Block MOs/NHM officials on demand generation activities
o Orientation of nodal school teachers on RI
o Orientation of NGO volunteers on RI
o Capacity building of media spokespersons
• ***Advocacy engagements with:***

o Religious leaders

o Local political leaders (MPs, MLAs)

o Advocacy meetings with key influencers (ward members/ councillors/ PRIs/teachers, local doctors, IAP/IMA members, CSOs, NCC, NSS, etc.)

• ***Social mobilization campaign*** through community networks (CBOs, community influencers, religious leaders, NGOs, youth volunteers, SHGs, Cooperatives etc.)

o Organize health camps in local MLAs and MPs constituency(s) and ensure their participation

o Institutionalize a reward and recognition system for well-performing ANMs/ASHAs

• District-level media management, including media orientation, press briefings

• ***Mass media***

o Airing of TV spots on local channels and cable TV

o Radio jingles on local FM channels

o Newspaper advertisements (English and Hindi)

o SMS campaign

o Printing of IEC materials

• Monthly district level meetings with ICDS, PRI, allied depts. for inter-sectoral convergence

Posters, pamphlets, flipbooks, hoardings, banners, flex boards, balloons

• Monthly and quarterly meetings of Inter-agency communications group and Integrated District BCC Cell

• Monitoring of communication activities

D) BLOCK COMMUNICATION PLAN The plan also includes proposed activities for interpersonal communication and community mobilization along with capacity building, coordination and advocacy and social mobilization initiatives. It needs to be planned by MOIC or Block managers looking into the necessity of their local areas

Communication activities at the block level will include the following:

• ***Capacity building***

o IPC skills training for frontline functionaries (ANM and ASHA)

o Orientation of nodal school teachers on RI

o Orientation of NGO volunteers on RI

• ***Advocacy engagements with***

o Religious leaders, PRI members, and key influencers (teachers, local doctors, CSOs, NCC, NSS)

• Community meetings

o Temple/mosque announcements

• Organize health camps in hard-to-reach/ underserved areas/resistant pockets

Social mobilization campaign through community networks (CBOs, community influencers, religious leaders, NGOs, youth volunteers, SHGs, Cooperatives etc.)

• ***IEC products including***:

o Posters, pamphlets, flipbooks, hoardings, banners, flex boards

• Monthly meetings with ICDS, PRI, allied depts. for inter-sectoral convergence

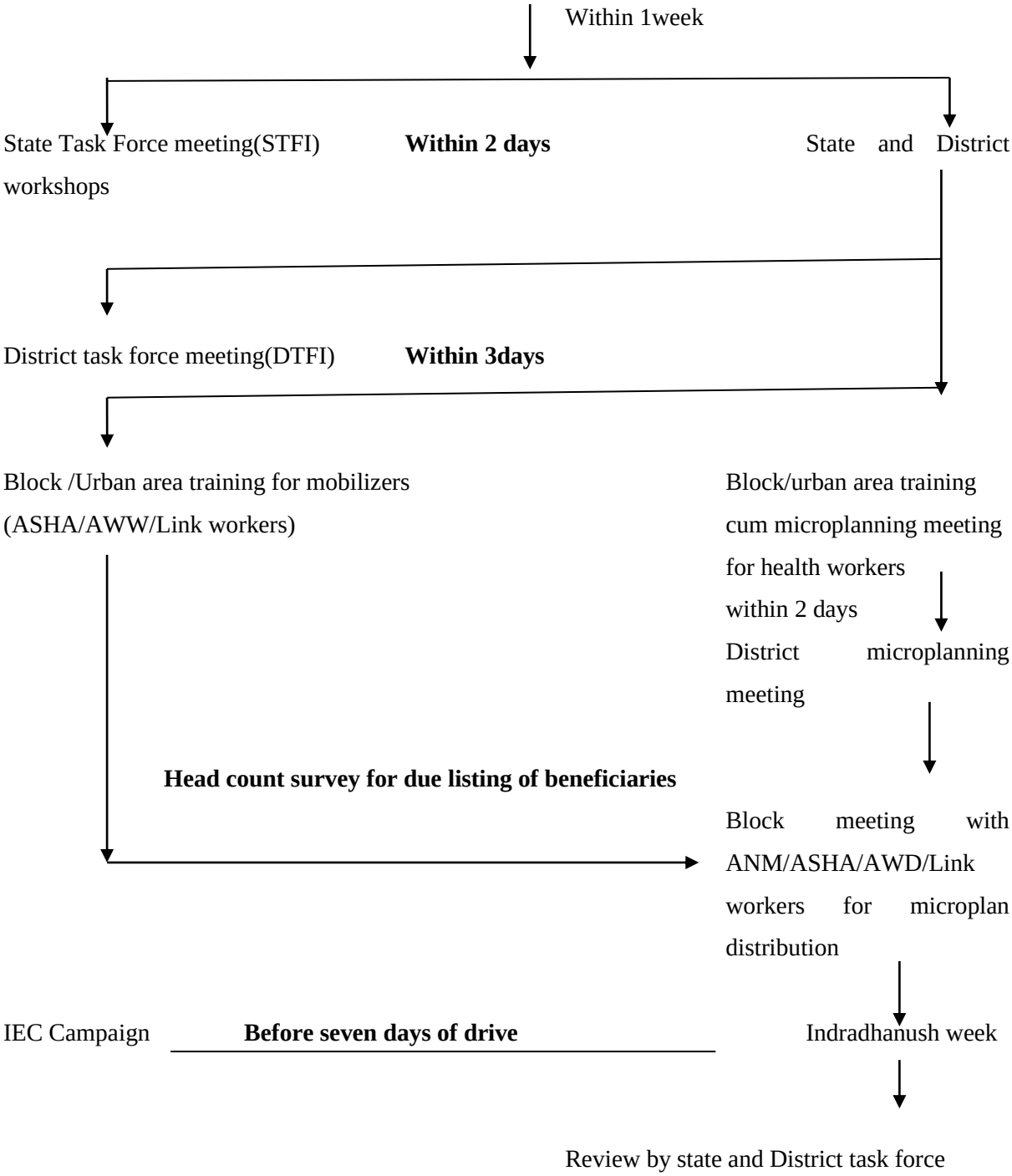
E) COMMUNITY-LEVEL COMMUNICATION PLAN:

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
- Announcements from locally situated religious places
- Community radio spots
- Mothers' meetings
- Community meetings
- Rallies
- Display of banners and posters
- Home visits by local mobilizers (ASHA/AWW/link worker) for IPC

ROLL OUT PLAN FOR MI

National Orientation Workshop



JHARKHAND

Formed in 2000 from the southern part of Bihar, with its capital in Ranchi, it is the 28th state of India. There are 24 districts, 211 blocks and 32615 villages.

Total population is 32,966,238 with 5237582 under the age of 0-6 years. Literacy rate is 67.6% with a sex ratio 947(Source-Census 2011).Infant mortality rate is 37 and Maternal mortality rate of 212(SRS2013).Total fertility rate is 2.3

HEALTH INFRASTRUCTURE OF JHARKHAND

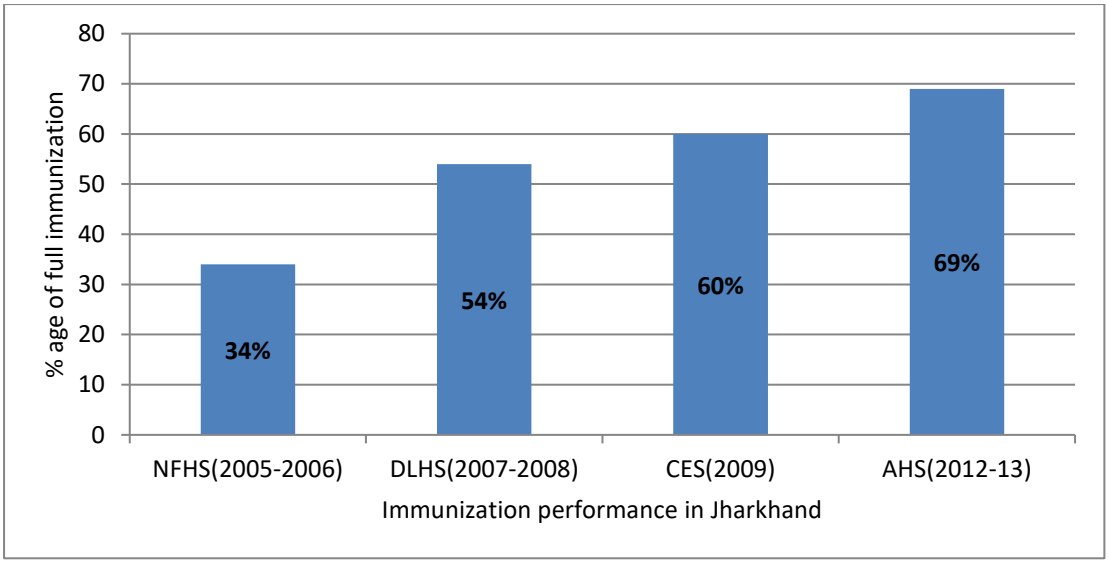
Type of facility	Total Facility	Active Facility(April 2015)
SC	3994	3972
PHC	381	335
CHC	258	252
SDH	13	13
DH	25	25
Total	4671	4597

Table2; Health infrastructure of Jharkhand; Source: HMIS Portal-Updated 2014-15

Category	Sanctioned(Regular)	Working(Regular)	Working(contract)	Working(regular +contract)
Medical Officer	2733	1656	0	1656
ANM	4617	2617	953	3570
Staff nurse	734	276	93	365
Health worker	582	164	0	164
Sahiya(ASHA				40496

Table3; Human Resource of Jharkhand; Source-HR cell, Jharkhand NHM Office (April2015)

STATUS OF UIP IN JHARKHAND



Graph3;Trend of UIP output; Source-NFHS,DLHS,AHS

FULLY IMMUNIZED CHILDREN (12-23 months) AND CHILDREN (0-5 YRS) WHO DID NOT RECIEVE ANY IMMUNIZATION IN DISTRICTS OF JHARKHAND(IN PERCENTAGE)

DISTRICTS	AHS(2010-11)		AHS(2011-12)		AHS(2012-13)	
Jharkhand State	63.7	3.9	69.1	3.6	69.9	3.1
Bokaro	79.0	1.9	82.4	1.7	82.5	1.6
Chatra	49.0	14.8	62.2	7.6	61.4	6.2
Deoghar	40.6	6.2	48.6	7.7	56.3	5.6
Dhanbad	60.2	2.0	67.2	2.2	69.3	2.0
Dumka	59.8	3.4	68.6	3.6	72.7	3.0
Garhwa	68.0	9.4	64.8	5.8	65.7	3.9
Giridih	28.0	10.9	43.0	9.8	46.5	9.4
Godda	44.1	10.7	54.0	5.9	55.9	4.5
Gumla	71.5	1.6	77.6	1.4	80.8	1.4
Hazaribagh	76.4	2.2	73.8	2.0	70.7	1.9
Koderma	58.5	3.3	65.1	3.4	61.8	2.7
Lohardaga	82.5	0.8	86.5	1.3	88.1	1.3
Pakur	45.7	5.2	54.9	4.4	47.6	3.4
Palamu	54.2	7.3	65.0	5.4	64.5	4.7

Paschimi Singhbum	64.7	5.0	77.1	3.0	74.5	3.1
Purbi Singhbhum	82.7	0.6	83.9	0.8	85	0.5
Ranchi	76.4	1.8	80.1	1.6	81.5	1.6
Sahibganj	54.9	10.5	60.7	7.9	57.9	6.4

Table 4;Immunization status of Districts of Jharkhand; Source: censusindia.gov(Annual Health Survey)

Rationale for selection of these High focus Districts in Jharkhand under MI

Nearly 2.39 Lakh children are either not immunized or partially immunized. We can clearly make out that the immunization rate in these six districts have been the lowest comparative to other Districts and with state data. In districts such as Pakur and Sahibganj there is decline in the immunization rate in 2013-13 against 2011-12.We can also make out that the proportion of children who did not received any immunization were highest in these six districts. So, in the first drive a major focus and concern was laid down for these six districts. Remaining districts will be covered in consecutive rounds.

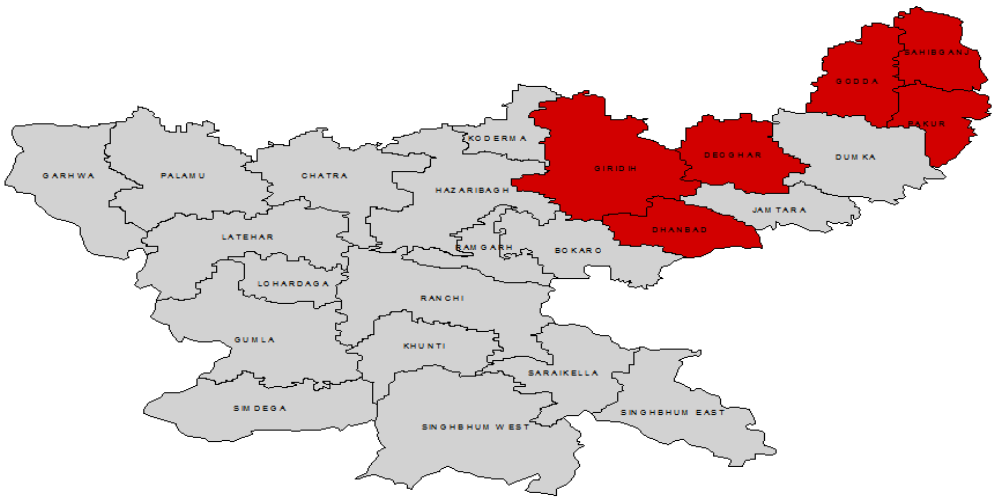


Figure1: Selected High Focus Districts for MI

Timeline of Mission Indradhanush in Jharkhand :

1st round : 7th – 14th April 2015

2nd round : 7th – 14thMay 2015

3rd round : 7th – 14thJune 2015

4th round : 7th – 14thJuly 2015

MONITORING CENTRE MAP FOR FIRST DRIVE

Figure 2: Districts of Jharkhand

DEOGHAR

Deoghar is a famous Hindu Pilgrimage Centre and one of the District Headquarters of Jharkhand state.Total population is 1492073(4.5% of total population of Jharkhand) with a literacy level of 64.85%.Sex ratio in the district is 925 female per thousand male.Constitutes nine blocks namely Karaon, Madhupur, Devipur, Jasidih, Mohanpur, Palazori, Sarath, Sarwan, Deoghar

Figure 3: Blocks of Deoghar

Type of Facility	Total Facility	Active Facility
SC	181	181
PHC	8	8
CHC	8	8
SDH	1	1
DH	1	1
Total	199	199

Table5; Health Infrastructure of Deoghar; Source- NHM, Jharkhand HR Cell

Post	Sanctioned	Posted	Vacant
Medical Officer	62	51	11
A Grade Nurse	14	16	-2
LHV	33	12	21
ANM		237	
Sahiya		2800	

Table6; Source: Status of Human Resource; Source -NHM, Jharkhand Office

Left Out and Drop Outs (%)

Year	Jharkhand			Deoghar (Out of Jharkhand)		
	Left Out (%)		Drop Out (%)	Left Out (%)		Drop Out (%)
	DPT3	BCG	DPT(1-3)	DPT 3	BCG	DPT(1-3)
2012-12	19	15	6	24	13	9
2013-14	11	10	5	9	-17	8
2014-15	19	13	6	-24	-11	7

Table7; Left out and drop out rate; Source-HMIS data from NHM office, Jharkhand

THE STUDY

OBJECTIVE OF STUDY-

General objective- To monitor and assess the overall process, implementation and functioning of Mission Indradhanush in Deoghar District of Jharkhand with special coverage in Blocks and session site.

Specific objective-

1. **Programme Management and intersectoral coordination**

- Sectors involved in planning and implementation
- Responsibilities of Participant sectors-Health Department, UNICEF,WHO,ICDS
- Differences in management and implementation process in four Blocks of Deoghar
- Implementation of MI at District level
  - Microplanning
  - Cold chain maintainance at Block level
  - Monitoring by state, district, block level and by developmental partners
  - Clarity regarding Financial Flexibility under MI

2. **Social Mobilization/Communication**

- Media and channels of message dissemination(IEC/BCC)
- Communication plan by Districts
- Role of NGO, Local bodies in communication at different blocks.
- Shortcomings of social mobilization

3. Overall gap analysis and suggesting necessary recommendations, both short term and long term at district level and block level for the next drive

Type of study-Descriptive study

Tool used

- District Assessment Checklist by MohFW, GOI (Annexure 6)
- Block Assessment Checklist by MohFW, GOI(Annexure 7)
- Session site monitoring

DURATION OF STUDY

6th April 2015-11thApril 2015

STUDY AREAS

District- Deoghar

Blocks covered under Deoghar

- Sarwan
- Sarad
- Jasidih
- Devipur

Session site monitored

- Kachuabagh(Block Sarad)
- Kapsa2(Block Sarad)
- Nandan Pahad 2(Urban Deoghar)

ACTIVITIES DURING THESE SEVEN DAYS

Sectors involved in planning and implementation and their responsibilities:

The various sectors involved and there functioning in MI in Deoghar districts were:

1. Health Department – National Health Mission (Jharkhand) and Health and Family welfare Department ,Jharkhand

- Headed by Mr. Amit Kumar(Deputy Commisioner) Dr. Divakar Kamad (Civil Surgeon),Deoghar. Immunization activity is looked upon by DRCHO officer, Dr.Sudhir Prasad.

- Various functions:

✓ DTFI meeting conducted twice at District level for MOIC, WHO and other NGO'S who were involved in the programme.

✓ Training of MOIC, Microplanning for entire drive

✓ Financial support for conduction of entire programme at block level

✓ Planning for IEC, despatching of IEC materials before the drive to block level.

✓ Monitoring at block level through district observer and Block development officer allotted from states.

2. WHO India provided technical support to district level 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. Headed by Dr.Roshan Thomas in Deoghar District .

- Various Functions

✓ 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 the implementation of the Indradhanush drive through daily monitoring.

✓ Provide monitoring feedback during task forces and other review meetings at district in evening review meeting.

3. UNICEF and CINI (Child in need Institute) India provided support for communication planning at District level (Nukkad Natak, miking) in the district) and cold chain maintenance at block level and dissemination of microplan

Plan for MI for these seven days

Micoplan was received by the districts from the blocks in advance which consists of:

Total number of headcounts to know number of beneficiaries of infants and to make a list to select unimmunized or drop out children. Also consisted of:

Number of sessions planned for each Districts

Number of ANM and Sahiya involved and trained in Mission Indradhanush

Areas allotted for each ANM either in same area/other block or other village

- ***Microplan for Deoghar District* (Annexure**

Name of the Block	No. of sessions	Target		No. of ANM involved
		0-2 yrs	Pregnant women	
Karown	43	1751	403	17
Madhupur	37	841	122	7
Jasidih	21	313	103	14
Sarwan	29	684	192	26
Sarath	39	1011	242	18
Palajori	27	862	185	19
Mohanpur	20	220	69	11
Devipur	45	1944	547	9
Urban	42	2417	494	7

Table8; Microplan for First MI in Deoghar; Source- District RCH office, Deoghar

- ***Reporting for MI***

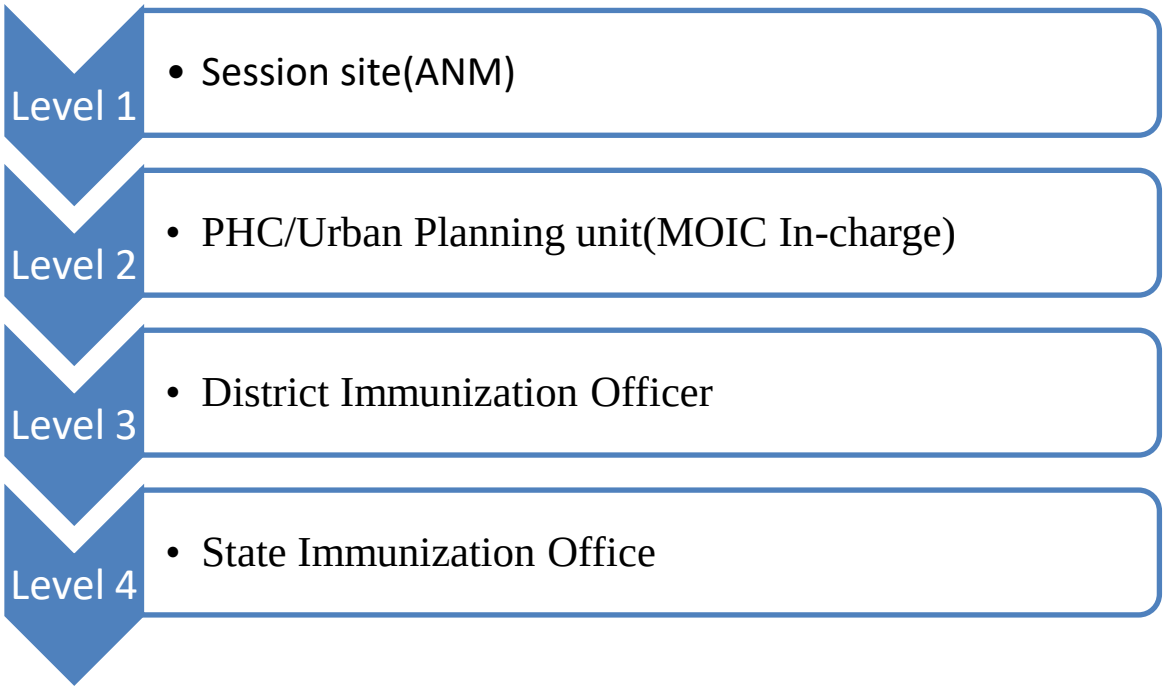


Figure 4:Hierarchy of Reporting

AT DISTRICT LEVEL

Mission Indradhanush drive was launched by District Commissioner, Deoghar on 7th April 2015 at Deoghar District Hospital by vaccinating children age 0-2years in the District Hospital premise

Image1-Inaugruation of MI at Deoghar

DTFI Meeting (District task force meeting)

Were conducted in two phases in Deoghar District- one on 19/3/2015 and the 4/4/2015.

Immunization planning during the seven days of the drive

- ANMs were involved in conducting sessions for Mission Indradhanush. On the designated routine immunization days, the ANM conducted sessions in high dropout/left out areas of her own sub centre or conduct her regular RI sessions. On the remaining 5 days, she was deployed within or outside her block in her district of posting, based on need. This mechanism was followed to tackle the existing human resource issues within the district.
- Major focus was given to the areas where refusal rate was high.
- All the immunization under UIP was provided along with the pentavalent vaccine in the District
- Pregnant mothers received Tetanus toxoid injection

IEC and Communication

- IEC material was printed and despatched from the District headquarter to Blocks one day before the drive.
- Some initiatives were taken at the block level by the local NGO's such as CINI and UNICEF such as miking and road play. Example in Devipur District, miking was done by MOIC.

Monitoring of Mission Indradhanush

- Four senior officers were reputed as district observers and these were assigned in eight blocks
- Session site monitoring and house to hose monitoring was done regularly area and block wise regularly

Evening review meeting

- At District Level

  Members included Civil Surgeon (chaired), DRCHO, WHO Monitoring officer and some other official staffs assigned as District observer.

AT BLOCK LEVEL

Four blocks covered were:

1. Jasidih
2. Sarwan
3. Sarad
4. Devipur

Mapping out of head counts was done by ASHA and reporting in the format(Annexure2) was done by ANM before the start of drive to MOIC.

Rosters for ANM were prepared in advance by MOIC and Block Manager for allotment of their respective session site, date and activities during seven days(Annexure4)

Microplan was made by the blocks and was sent to District RCHO Officer.

Image2-Community Health Centre, Devipur Block,Deoghar

Image 3-Community Health Centre,Sarwan

Microplan for all four blocks

Name of the Block	Total no. of ANM in the Block	Nos. Of ANM involved in MI	Nos. of ANM deployed outside the subcentre	Nos. of ANM deployed outside the Block	%age of ANM/ASHA trained for MI
Jasidih	46	14	4	0	92;92
Sarath	35	18	6	0	97;90
Sarwan	52	26	1	0	100;100
Devipur	16	9	2	0	97;100

Table 9:Microplan for all four blocks

Communication Planning

Name of the Block	Guidelines received from state regarding communication planning(Yes/No)	Has block prepared a communication plan for MI?(Yes/No)	If yes, does the plan include special activities for High Priority Districts?
Jasidih	Yes	No	No
Sarath	Yes	No	No
Sarwan	Yes	No	No
Sarath	Yes	Yes	Yes, Miking

Table 10: Communication planning for the blocks

Image4-IEC for MI for Deoghar District

Image5-IEC for MI

Cold chain functioning

Name of Block	Number of ILR Present; functional	Number of Deep Freezer Present; Functional	Cold Chain Handler trained for MI(Y/N)	Remarks
Sarad	3/3	3/3	yes	Thermometer present ; Log book not updated
Jasidih	1/0	3/3	yes	Thermometer present, log book not updated
Sarwan	2/2	1/1	yes	Thermometer was not working in one; log book not updated
Devipur	1/1	1/1	yes	Thermometer present; log book updated

Table 11: Cold chain status in four blocks of Deoghar

Note-Daily reporting of logistics,vaccines and syringes need to be done using Annexure 5 and submit it to District Office

AT SESSION SITE

Kachuabagh Session site (Block Sarad)

- Majority of population were Muslims in the village
- IEC Material was received by ASHA/ANM one day before the drive to start and it was not at all displayed and pasted on the session site
- No local communication activities other then IEC were conducted.
- No ASHA (Sahiya) was allotted in the session site. Helper for ANM conducted head count and other activities.
- Refusal rate of two to three.

Kapsa 2 (Block Sarad)

- IEC materials pasted and displayed in around session site.
- ANM and Sahiya both were present
- Sahiya was not clear about head count, ANM performed the head count and microplan was verified.
- ASHA was not much aware about the entire programme.

Nandan Pahad (Urban area-Deoghar)

- Headcount,tally sheet present and verified
- IEC material were displayed properly
- ANM present, posted from other block but trained for MI.
- Two Sahiya's were allocated for this session site, both trained for MI.
- A vaccine vial was found without expiry and opening date.

OTHER FINDINGS

- Lack of Human resource at Block level- At some places (Devipur),Account manager was handling the responsibility of Block Manager. In Blocks where one MOIC is there it is difficult to manage planning ,training of health workers for at least 10-15 subcentres approximately and to follow up.
- ASHA/ANM faces a lot of difficulty in reaching to a hard reach areas where there is no way of communication. And local conveyance to these areas are minimally accessible creating trouble for them in reaching timely during the session
- Not a single MOIC were aware of the letter which were sent for ANM from Mohfw and therefore was not despatched to anyone.
- Daily review meetings were conducted by Block MOIC ,Block development officer after collation of reports from ANM at the end of the session and the reports were send to District Headquarter.

RECOMMENDATIONS

Short term recommendations

- DTFI meeting should involve compulsory participation from IMA members, IAP members and other Rotary members so that the necessary information should be collated regarding planning of MI in advance.
- Microplan from the block level should be submitted at the District level at least 15-20 days in advance to the drive so that necessary changes and planning could be made accordingly.
- More focus on training for ASHA regarding headcount especially practical exposure is needed.
- Transportation facility for ANM and ASHA should be provided from block level for the easy reachability to hard reach areas to be in time during the session.
- Communication Planning from the block level should be focused more and engagement of NGO (CINI, UNICEF) should be involved to focus local people and unreached areas like miking ,drum beating etc.
- Training of Block Managers is of utmost need because he is involved in coordination of various activities for MI at village and subcentre level.
- ASHA(Sahiya) should be trained rigorously for motivation of community members.

Long term recommendations

- Strengthen the programme management skills of the lower- and mid level managers, specially block managers to address the high dropout rates and low proportion of fully immunized infants.
- Revitalize and strengthen routine immunization services with particular reference to urban areas, Muslims, illiterate parents, populations residing in the plains, and population groups or areas hitherto not reached as a major portion of population in Deoghar blocks consists of Muslim Population. Ensure regular immunization services on a fixed day and fixed place basis.
- Addressing the issue of poor utilization of immunization services, obstacles and lack of awareness or motivation, through professionally designed behavior change communication interventions through ASHA and ANM.
- More focus on IEC should be made in future, targeting grassroot people starting from small villages rather than just focusing on district level and block headquarters(CHC/PHC)

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LISTS OF TABLES, GRAPHS AND FIGURES

Tables

Graphs

Figure

Images

Annexure 1. 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 micropla n	Available ANM days utilized			Additional ANM days required (need based) from other blocks for conducting Mission Indradhanush sessions
					Within ANM's own sub-centers	In other sub-centres within same block	For supporting activity outside block	

Signature of District Immunization Officer

Annexure 2: Mission Indradhanush Sub-centre planning (Format 1)

For ANM

(MOIC 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 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	Write 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.

1. Vacant sub center
2. Areas with last three RI sessions not held
3. Polio high risk areas
4. Areas with low RI coverage, identified through measles outbreaks or cases of diphtheria/ neonatal tetanus in last two years
5. Small villages, hamlets etc. not having independent RI sessions
6. Others

Signature of ANM

Annexure 3. 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 centers:_____ Number of ANMs:_____ Number of vacant sub center:_____

S. No	Name of sub center	Name of areas Requiring Additional Indradhanush Session	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 center	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.				

* 1. Vacant sub center

2. Areas with last three RI sessions not held

3. Polio high risk areas

4. Areas with low RI coverage, identified through measles outbreaks or cases of diphtheria/ neonatal tetanus in last two years

5. Small villages, hamlets etc. not having independent RI sessions 6. Others

Signature of MOIC

Annexure 4. ANM microplan roster for Mission Indradhanush (Format 3) Round I / II / III / IV

(One format for each ANM in the district)

District_____ Block/ planning unit: _____

AEFI management center name & Tel no: _____

MOIC (name & mobile): _____ Supervisor (name & mobile): _____

ANM (name & mobile): _____

Sub-center of ANM

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

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

Signature of ANM Signature of MOIC Signature of District Immunization Officer

Annexure 5. 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	Measles	Measles Diluent	TT	JE	JE Diluent	AD Syringes 0.1ml	AD Syringes 0.5ml	5ml Reconst-itution Syringes
Day 1														
Day 2														
Day 3														
Day 4														
Day 5														
Day 6														
Day 7														
Day 8														
Day 9														
Day 10														

Signature of MOIC

Name and signature of cold chain handler

Annexure 6-DISTRICT ASSESSMENT CHECKLIST, MISSION INDRADHANUSH

State: _____ District: _____Name of monitor: _____

Organization:_____ Date/s of visit:_____

District-level information		
Monitors should meet DM, CMO, DIO and other district-level officers for advocacy of Mission Indradhanush and to debrief them about their observations with suggested corrective actions.		
Status of DTFI meeting	***Discussion points for DTFI***	***Partners invited to DTFI***
☐ held ☐not held *Minutes available*☐Yes☐No	☐Preparedness of blocks☐IEC plan ☐Printing of communication materials☐Deployment of district observers ☐Role of partners☐Launch of Mission Indradhanush drive☐Vaccine & logistics	☐WHO☐UNICEF ☐Rotary☐CORE ☐RMNCH+A partners☐IMA ☐IAP☐Others (Specify_____)☐not held
Has DM chaired the DTFI meeting for Mission Indradhanush?		☐ Yes ☐ No
Has any "nodal officer" been identified for urban areas in the district?		☐ Yes ☐ No
Has any state observer been assigned to the district?		☐ Yes ☐ No
Has district received Mission Indradhanush communication from state HQ?		☐ Yes ☐ No
Has district issued communication regarding Mission Indradhanush to blocks?		☐ Yes ☐ No
Financial norms for Mission Indradhanush		
Does district have clarity on financial norms? Is DIO aware of flexibility under Mission Indradhanush?		☐ Yes ☐ No
Does DIO have clarity on funding for IEC?		☐Yes☐No
Implementation of review mechanism		
From district level, how will implementation of Mission Indradhanush be reviewed with blocks?		☐Daily evening meeting with DM ☐Daily evening meeting with CMO ☐ Daily evening meetings at block ☐ DTFI after each round ☐Others,specify:
Microplanning		
How many blocks have submitted microplans for Mission Indradhanush to district? (Verify)		_____ out of _____ blocks
How many vacant sub-centres have been identified in district?		___ out of ___ sub-centres
How many sessions have been planned under Mission Indradhanush drive?		

Is the selection of sessions as per operational guidelines?	☐ Yes ☐ No
Has headcount (for children <2 years and pregnant women) been done as part of microplanning?	☐ Yes ☐ No☐ Not aware
Is there a plan in place for preventive maintenance of cold chain equipment in district?	☐ Yes ☐ No
Trainings	
Which district-level trainings have been conducted in district?	☐Medical officers ☐NHM finance officials ☐ Cold chain handlers ☐ Data handlers
Proportion of frontline workers trained for Mission Indradhanush in district.	____% health workers; _____% mobilizers
District-level communication planning	
Has district received any guidelines for communication planning?	☐ Yes ☐ No
Has district prepared a communication plan for Mission Indradhanush? (Verify)	☐ Yes ☐ No
What are the modes of IEC planned by district for Mission Indradhanush?	☐ Miking ☐ Drum beating ☐ TV ☐ Radio ☐ Newspaper ☐ Pamphlets ☐ Poster ☐ Leaflets ☐ Street Banner ☐ Session Banner ☐ Hoarding ☐Social media☐Flex boards ☐Balloons ☐Others, specify:
Where have the IEC materials been printed?	☐ At state level ☐ At district level ☐ Both levels (state anddistrict) ☐Not aware☐Others, specify:
If printed at district, have any prototypes been received fromstate level?	☐ Yes ☐ No
Planning for monitoring of Mission Indradhanush	
Has district identified senior officers to be deputed as districts observers for Mission Indradhanush?	☐ Yes ☐ No☐ Not aware
If yes, provide the no. of blocks in which district observers have been assigned?	☐
Does the district observer monitoring plan include the following details?	☐ Transportation support☐Briefing and debriefing ☐ Utilization of standardized monitoring format☐Attending evening feedback meetings ☐Others, specify:
What are the components of monitoring checklist being used by district and state observers?	☐Communicationmonitoring☐Session site monitoring ☐House-to-house monitoring
Have monitors been briefed regarding filling of monitoring format?	☐ Yes ☐ No☐ Not aware
Remarks/Comments(if any):	

Signature of National Monitor……

ANNEXURE7-BLOCK ASSESSMENT CHECKLIST, MISSION INDRADHANUSH

State: _____District: _____Block/PHC/Urban area: _____ Date of visit: _____

Name of Monitor:

_____Organization:_____

Block-level information	
Did MoIC attend the DTFI meeting for Mission Indradhanush?	☐ Yes ☐ No
Is MoIC aware of Mission Indradhanush guidelines on planning and implementation?	☐ Yes ☐ No
Is MoIC aware of any district/ state observer that has been assigned to this block?	☐ Yes ☐ No
Have all medical officers in the block been oriented onMission Indradhanush?	☐ Yes ☐ No
Financial norms for Mission Indradhanush	
Is MOIC aware of financial norms flexibility under Mission Indradhanush?	☐ Yes ☐ No
If yes, is he/she aware of flexibility in providing incentives to mobilizers?	☐ Yes ☐ No
Has block accounts officer attended district-level orientation training for Mission Indradhanush?	☐ Yes ☐ No ☐ Not aware
Has block/urban body received any funds forIEC?	☐ Yes ☐ No ☐ Not aware
Implementation of review mechanism	
What is the plan to review implementation of Mission Indradhanush in block/urban area?	☐ Daily evening meeting by district observer ☐ Daily evening meetings by MoIC ☐Through deployed block level observers ☐ Others (Specify_____) ☐ Not aware
Microplanning	
Has block/urban areasubmitted Mission Indradhanush microplan to district?	☐ Yes ☐ No☐ Not aware
Mention the total no. of ANMs in block/urban area.	___
How many vacant sub-centres have been identified in block (for example: 4 vacant/25 total sub-centers)?	____ vacant out of ____ total sub-centres

How many Mission Indradhanush sessions have been planned in block/urban area?	____
Has headcount for estimation of beneficiaries been undertaken for sessions planned under Mission Indradhanush?	☐ Yes ☐ No☐ Not aware
Does Mission Indradhanush microplanning include the following components?	☐ Urban/peri-urban areas ☐ Mobility for mobile teams ☐ Mobility for supervisors ☐Vaccine & logistics plan☐Social mobilization plan
How many ANMs in the block/ urban areaare involved in Mission Indradhanush?	___
How many ANMs of this blockhave been deployed to work outside their sub-centre area?	___
How many ANMs of this block have been deployed to work in a different block/ urban area?	___
How many supervisors have beenidentified for the activity?	___
Vaccine, logistics and cold chain	
Did cold chain handler of this block/urban area attend district-level Mission Indradhanush orientation training?	☐ Yes ☐ No ☐ Not aware
How many cold chain points out of total number of cold chain points were visited at least once in last 3 months as part of preventive maintenance of cold chain?	_____visited out of____ total cold chain points in block/urban area
How many non-functional ILRs or DFs are identified in the block/urban area?	____ of ____ ILRs ; ____ of ____ DFs

Has there been shortage of any vaccine or AD syringes (0.1 ml or 0.5 ml) or reconstitution syringes (5ml) in the block/urban area?	☐ Yes ☐ No ☐ Not aware
If yes, please specify the details of shortage.	
Trainings	
Proportion of frontline workers trained in block/ urban area for Mission Indradhanush.	____% health workers; _____% mobilizers
Which training materialswere used for training of ANMs?	Verify physically and Specify
Which training materialswere used for training of ASHAs/AWWs/link workers?	Verify physically and Specify
Standardized formats in use as per guidelines	
Standardized formats in use at block level (refer to operational guidelines). Encircle the appropriate option.	☐ Reporting immunization coverage ☐Reporting vaccine and logistic utilization ☐ ANM microplan roster (Annex. 11) ☐ Mobile team planning (Annex. 12) ☐ Tally Sheet (Annex.14) ☐Monitoring format
Block level communication planning	
Has MoIC received any guidelines for communication planning from district?	☐ Yes ☐ No ☐ Not aware
Has block/urban area received any Mission Indradhanush IEC materials from district?	☐ Yes ☐ No ☐ Not aware
Has block/urban area prepared a communication plan for Mission Indradhanush? (Verify)	☐ Yes ☐ No ☐ Not aware

If yes, does the plan include special activities for high priority areas/difficult to reach areas?	☐ Yes ☐ No
What are the modes of IEC used for Mission Indradhanush in block/urban area?	☐ Miking ☐ Drum beating ☐ Pamphlets ☐ Poster ☐ Leaflets ☐ Banner ☐ Hoarding ☐ Social media☐ Flex boards ☐ Balloons ☐Others, specify:
Letter (message) from Hon'ble Health Minister for all ANMs/ASHAs Has block distributed this letter to all ANMs and ASHAs in block/urban area?	☐ Yes ☐ No ☐ Not aware
Does MoIC know about Mission Indradhanush tagline'*be wise……fully immunize orsamajhdaarbaniye……sampooranteekakarankaraien'?*	☐ Yes ☐ No
Remarks/Comments(if any):	

Signature of National Monitor