Micro Planning for Immunization Activities

Health Managers Modules for Immunization
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Foreword

The Universal Immunization Program, launched in 1985 for reducing deaths and disabilities due to vaccine preventable diseases in the country, has received a special impetus through the National Rural Health Mission (NRHM). The strengthening support provided by NRHM includes funds, resources, strategic guidelines and contractual manpower for program management. Since 2005, when the NRHM came into effect, there has been an increasing trend in Immunization coverage and quality.

Child Health managers introduced to manage and oversee child health and immunization in select districts of low performing states, as well as other health managers from non-medical background introduced through the NRHM, was found to have an increasing role in the Immunization Program. However they often came with no prior knowledge, experience or skills related to management of the Immunization program. Their roles and therefore their requirement in the program were identified as being a mixture of technical, supervisory and managerial. This set of modules covers many of these aspects, and have been developed for self as well as collective learning by program managers and supervisors.

The modules have been compiled from existing literature related to the Immunization program and health management available in India with the Ministry of Health and Family Welfare as well as with UNICEF, WHO, USAID and PATH. The materials have been adapted to meet the requirements at the primary levels of health program management in the country, particularly at the sector, block and district levels.

The National Child Health Resource Center (NCHRC) at the National Institute of Health and Family Welfare (NIHFW) has worked closely with national trainers in Immunization at the NIHFW and the Immunization officer of United Nations Office for Project Services, Norway India Partnership Initiative (UNOPS-NIPI) in developing these modules. The pilot testing of these modules has been conducted in Orissa, Bihar and Rajasthan involving the district, block and sub block level managers and supervisors along with select state level trainers, and their feedback has been incorporated. UNOPS-NIPI has been instrumental in identifying the need for improving program management at implementation levels as an important step to achieve enhanced program coverage and quality, and have also provided the required support for the development of these modules.

We hope that this set of module will prove to be useful in enhancing the capacity of managers and supervisors at implementation levels for improving quality and coverage of Immunization.

Dr. Kaliprasad Pappu  
Director,  
UNOPS-NIPI LFA  
New Delhi

Prof. Jayant K. Das  
Director,  
National Institute of Health and Family Welfare  
New Delhi
<table>
<thead>
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<tr>
<td>AEFI</td>
<td>Adverse Effects Following Immunization</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal checkup</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<tr>
<td>AVD</td>
<td>Alternate Vaccine Delivery</td>
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<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guérin</td>
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<tr>
<td>CHC</td>
<td>Community Health Center</td>
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<tr>
<td>DPT</td>
<td>Diphtheria Pertussis Tetanus Vaccine</td>
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<tr>
<td>ECP</td>
<td>Emergency Contraceptive Pill</td>
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<tr>
<td>ENBC</td>
<td>Essential New Born Care</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HW</td>
<td>Health Worker</td>
</tr>
<tr>
<td>ICDS</td>
<td>Integrated Childhood development services</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<td>IFA</td>
<td>Iron and Folic Acid Tablet</td>
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<tr>
<td>ILR</td>
<td>Ice-Lined Refrigerator</td>
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<tr>
<td>JSY</td>
<td>Janani Suraksha Yojana</td>
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<tr>
<td>MCHN</td>
<td>Maternal Child Health and Nutrition</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>OCP</td>
<td>Oral Contraceptive Pill</td>
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<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
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<tr>
<td>ORS</td>
<td>Oral Rehydration Solution</td>
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<td>PHC</td>
<td>Primary Health Center</td>
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<td>PIRI</td>
<td>Periodic Intensification of Routine Immunization</td>
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<tr>
<td>PRI</td>
<td>Panchayati Raj Institutions</td>
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<tr>
<td>RH</td>
<td>Referral Hospital</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>SC</td>
<td>Sub center</td>
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<tr>
<td>SC/ST</td>
<td>Scheduled Caste/Scheduled Tribe</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TT</td>
<td>Tetanus Toxoid Vaccine</td>
</tr>
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<td>VHND</td>
<td>Village Health and Nutrition Days</td>
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<tr>
<td>VHSC</td>
<td>Village Health and Sanitation Committee</td>
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<tr>
<td>WMF</td>
<td>Wastage Multiplication Factor</td>
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Objectives of this module

• Explain to the managers, the need and process for developing micro plans for immunization program.

• To familiarize the health managers with the steps in developing a comprehensive and equitable micro plan

• To help health managers plan beyond immunization services for village health and nutrition days

• To help managers develop special and supplementary plans for supervision, vaccine movement and special areas

• To familiarize managers with various tools and formats used for immunization planning.

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2D. PLANNING FOR HEALTH AND NUTRITION DAYS
2E. PLANNING FOR SPECIAL AREAS
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2G. TOOLS FOR MICRO PLANNING
A. Planning for Immunization: Basics

1. What is the need for planning for the Immunization program?

The Immunization program is a large scale public health program. It is often a program with extensive reach. Immunization activities are usually planned to reach every community, area and village. Often other programs for health service delivery can be added to the immunization program. The immunization program needs to be well – planned to reach every child individually.

The success of the Immunization program depends on how well immunization sessions are organized. Through a well organized session, it should be possible to ensure maximum targeted beneficiaries avail immunization and other health services. As an immunization program with extensive reach and coverage will involve organizing a large number of immunization sessions, it is important to plan for them precisely and effectively. If one fails to plan, one is actually planning to fail!

The ultimate goal for the immunization plan is to ensure all areas are provided with immunization services in a feasible, realistic and efficient manner. The plan should also be comprehensive and have the details of where, when, who and how the immunization services are being delivered.

2. What is the process for planning of Immunization program?

Preparing micro plans for the immunization program should ideally be a part of the planning involving other health programs and services. Such planning usually is undertaken at the closure of one year cycle so that budgets can be prepared for the forthcoming year.

Planning usually should be bottom up, beginning at village and sub-center following a community survey. At the sub center level, the health worker prepares a session plan/ duty roster in consultation with community representatives such as the ICDS worker, ASHA and PRI members. At higher levels such as PHC and Block other plans such as the supervisor plan and the vaccine delivery plan are prepared.

At the district, planning involves compiling block-wise plans and working out budget and funds and requesting to the state.

The state level provides policy, strategy and framework, operating procedures as well as funds and other resources.

This module is also designed to help managers and planners understand the general principles of micro plan preparation and then create / follow operating procedures as required in their areas.

3. What is the planning unit for Immunization sessions?

Since the basic plan for immunization is prepared at the Health sub-center, it is also called the planning unit for immunization sessions.
4. What are the different types of immunization sessions that need planning for?

There are several strategies for the routine delivery of immunization services in and from health facilities.

**Fixed facility:** This refers to the regular delivery of vaccinations in a health facility on specified days of a week and hours of the day, such as, the immunization clinics in District, Sub-divisional and referral hospitals and even larger Community and Primary Health centers. Vaccines are stored in ILRs in these fixed facilities and are easily available when needed.

Busy facilities need planning for daily immunization sessions, ensuring skilled vaccinators are available on all these days as well as the vaccines and logistics needed for the sessions.

**Outreach:** Outreach is the delivery of services to people who stay far away from the health facility and vaccines need to be delivered to their villages and areas for the immunization sessions. Outreach sites have no arrangement for overnight storing of vaccines and trips to the outreach sites for the immunization sessions are completed within a day. In India the outreach sites are Sub centers, Anganwadi centers, urban and village session sites etc.

**Mobile strategy:** To reach remote or hard-to-reach areas, vaccination teams with adequate logistics need to be formed with the arrangement of the appropriate modes of transport (ranging from boats, tractors, four wheel drives, porters etc.). These remote areas may not be accessible in all months of a year and good planning has to be made to reach them during the accessible months. These mobile teams would then move to these areas, as planned, to vaccinate the eligible beneficiaries. To complete the vaccination schedule at least four such visits should be planned in the course of a year.
5. Who prepares the micro plan?

Session micro plans of villages and urban vaccination areas need to be made by the local health worker in consultation with the village link workers such as the ASHA, Aganwadi and other village representatives (VHSC).

Compilation at the sector /PHC /Block level should usually be undertaken by the Health manager in consultation with the supervisors and health workers. In times of any dispute the in-charge medical officer should make the final decision.

6. What should be the objectives of preparing an immunization micro plan?

The following objectives would help in making a good immunization micro plan

1. Ensure no left out areas
2. Ensure equity and uniformity in work load distribution while planning, optimize available resources.
3. Prepare comprehensive session plans through participatory process including the who, how, what, where and when.
4. Prepare special area plans where regular activity is not possible
5. Prepare a plan to outline management at the ILR point: including supervision, alternate vaccine delivery and logistics management plan for MCHN activities.
6. Ensure planning for services other than immunization which can be combined.

7. **What are the steps involved in preparing a micro plan?**

The steps involved in preparing a micro plan should ensure all the primary objectives of micro plan preparations are met.

In this respect while the initial planning can be done at a higher level to ensure no missed areas, the detailed planning of who, where, when should always be undertaken at the Health sub center level.

Following this, any areas needing special plans such as mobile teams should be taken up.

Thereafter, the planning at the vaccine management site, usually the most peripheral ILR point or PHC takes place. Supplementary plans such as for vaccine delivery, supervision, social mobilization and a working roster can be prepared.

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**Knowledge Test**

1. What is the recommended approach for planning?
   a) Starting from higher levels and go to lower levels (Top down approach)
   b) Starting from lower level to higher level (Bottom-up approach)
   c) Starting at all levels simultaneously
   d) None of the above

2. What is the lowest management unit in India where immunization sessions should be/are planned?
   a) Village
   b) Sub-centre
   c) PHC
   d) Block

3. What are the different strategies for routine delivery of immunization services?
   a) Fixed facility
   b) Outreach sessions
   c) Mobile strategy
   d) All of the above
   e) None of the above
4. Name the strategy used to deliver routine immunization services in remote and hard-to-reach areas?
   a) Fixed facility
   b) Outreach sessions
   c) Mobile Strategy
   d) None of the above

5. What are the elements of a good micro plan?
   a) Coverage of all areas & ensuring no left out areas
   b) Optimizing use of available resources
   c) Ensuring equity & uniformity in work load distribution
   d) Planning for other MCH services which can be combined with immunization
   e) All of the above
8. How to ensure all areas are covered?

In order to ensure all possible areas are covered one has to utilize multiple sources of information about existing areas. A comparative list of villages, urban areas, hamlets etc. made by combining the sources usually helps in finding out whether areas had been missed earlier.

The following steps are suggested for preparing such comprehensive village/area lists:

1. List out all villages within a PHC/Block using multiple sources
2. Identify villages/areas with pockets of left out beneficiaries through desk-work comparing several village and areas lists (census, e gram, polio micro plan, block village lists with current Immunization and other outreach activity micro plan)
3. Allocate these villages to existing sub-center/facility areas which are manned by health functionaries.
4. Ensure that these villages/areas are now included in the session-wise micro plans to be prepared by health staff of individual health centers.

Is not my sub center plan of last year sufficient to find out missed areas?

Comparing various lists of villages from different sources helps in finding out whether areas are missing from existing sub-center plans.
It is important to note the hamlets, temporary settlements and migratory populations while doing this exercise. If some of these areas are difficult to reach or allocate to any health worker for regular activity, then such places are best kept for special plans using mobile teams etc.

It is also important to distribute areas equitably between health workers if this has not already been undertaken.

One of the key problems encountered during micro plan preparation is unequal distribution of areas between different workers. This needs to be identified and corrected before proceeding further.

9. How can equitable distribution of health workers areas be undertaken?

In order to ensure equitable distribution of areas among available workers, bear in mind geographical distances, travel facilities and time taken to reach various areas as well as the population density and proximity of various villages and areas as you work out the health sub-center wise area plan.

The steps are as follows:

1. List out health sub centers and their allocated villages, hamlets and areas with their populations
2. Use a map if available and shade the area belonging to each sub-center or health facility.
3. See if there is a gross variation in the populations and area distribution among the health sub-centers.
4. Identify difficult to reach areas and areas with other problems and difficulties for special planning.
5. Redistribute areas among health workers keeping equity and feasibility in mind. Ideally each sub center should have two health workers, but it is important to ensure that every sub-center has at least one regular health worker posted and working there to begin with.

I do not want my area changed or added, I have enough work already!

If any area gets left out, the beneficiaries there may remain unvaccinated. Finally there will be disease outbreaks and all of us will be responsible.
10. Are there any areas with health worker shortage despite re-planning?

1. Look at other options like increasing the number of immunization days (often the additional days for immunization e.g. vaccination days in some areas are underutilized, a little rearrangement of health workers away from their traditional areas on these days would often solve this problem).

2. You could also look for retired persons / private workers to help out with vaccination on session days if available and pay them the funds available for hiring alternate vaccinators.

3. Be sure the distribution of health workers are uniform and that some areas do not have several health workers at the expense of some unmanned areas.

4. As a final recourse, the district would have to be intimated for severe shortages and hiring contractual health workers through NRHM should be considered.

Knowledge Test

1. In order to ensure Immunization coverage of all possible areas, within a Sub Centre one has to utilize information about the existing villages/areas from
   a) A single reliable source
   b) Sub-centre records
   c) Multiple sources (e.g. Census, previous records, polio micro plan, community survey)
   d) ANMs working in SC

2. The following steps are suggested for preparing comprehensive village areas lists –
   i. List out all the villages and hamlets within PHC / Block using multiple sources
   ii. Identify villages / areas with pockets of left out beneficiaries through desk-work comparing several village and areas lists (census, ‘e gram’, polio micro plan, block village lists with last year’s immunization and other outreach activity micro plan)
   iii. Allocate these villages to existing sub-centre / facility areas which are manned by health functionaries
   iv. Ensure that these villages / areas are now included in the session-wise micro plans to be prepared by health staff of individual health centres

   From the above steps –
   a) Only (iv) & (i) are true
   b) Only (ii) & (iv) are true
   c) Only (iii) & (iv) are true
   d) All of the above are true

3. In which situation will revision of micro plan help most?
   a) Shortage of funds
   b) Villages and hamlets with no immunization sessions planned
   c) Irregular supply of vaccines
   d) Lack of transportation to deliver vaccines
C. Planning for Immunization sessions

11. How are session level plans made?

Each session plan should be made at sub-center level by the concerned health worker in consultation with village link workers (ICDS worker, ASHA) and village representatives.

Usually a format for planning is made available to the Health worker who will be able to fill it as she/he makes the micro plan.

A sample of the format can be seen below. The steps outlined below can be followed to prepare it.

Step 1: Village and habitations listing

- List all villages and hamlets in SC area (in column Village#)
- If hamlets have too small a population, tag these along with larger nearby villages. No matter how small the hamlet/group of habitations, mentioning their names in the micro plan would help ensure beneficiaries, such as pregnant women and children, from these areas are not excluded from the immunization services.

Step 2: Arriving at the population

- Write population of each village and hamlet based on actual headcount/survey (in column Total Population#)
Step 3: Arriving at the Target beneficiaries

- Write the annual target of pregnant women and infants (in the column Annual Target#)
- The target may be arrived at based on the actual number of infants counted during the headcount.
- Pregnant women target can also be derived by doubling the number of pregnant women counted at the time of any survey (Reason: The headcount would provide a point estimate for only 6 months (as pregnancies in the first trimester may be undetected). Hence, multiply the headcount by 2 to arrive at an estimate for 12 months).
- Example: 30 Pregnant women were counted in January 2011, how many would be the annual estimated number of pregnant women: 30*2=60 pregnancies.
- Another way of estimating number of pregnant women is by 10% to the number of infants

Example: Headcount of infant is 50. Pregnant women would be estimated at 50*1.10=55)

Targets are best arrived by an annual survey undertaken by the local ICDS worker and ASHA along with the health worker. This also helps in updating the beneficiary list name-wise.

Step 4: Setting monthly targets

- Write the monthly target of pregnant women and infants (in the column Monthly Target#)
- This is achieved by dividing the annual target of infants and pregnant women by the number of months in a year (12)

Step 5: Estimating vaccine requirement in doses. (In columns e to l#)

- Vaccine requirement for all beneficiaries expected is to be calculated and mentioned in the micro plan.
- These are usually calculated village-wise.
- When calculating the vaccine requirement, keep in mind the number of doses of the vaccine to be administered.
- For example, in the schedule 1 dose of BCG and 5 doses of DPT are recommended: the calculation as follows then should be done:
  BCG = Monthly target of infants x 1 dose
  DPT = Monthly target of infants x 5 doses
  OPV = Monthly target of infants x 5 doses
  Hep B = Monthly target of infants x 4 doses
  Measles = Monthly target of infants x 2 dose
  Vit. A = Monthly target of infants x 9 doses
  TT * = Monthly target of pregnant women x 3.5 doses

(Keeping in mind the TT booster doses and those at 10 and 16 years)
(In states with other vaccine in the immunization schedule, it would be appropriate to include them in the calculation)
Step 6: Calculating the monthly vaccine requirement in vials: (in columns m to t#)

- To calculate the requirement of vaccines in vials, the doses of vaccines packaged per vial is to be known.
- Thereafter wastage of 25% is to be considered. This amount is to be added to the initial requirement and is done by multiplying with a wastage factor of 1.33.
- Since, TT, DPT, BCG, Hep B all come in 10 dose vials the calculation will be:
  \[ \text{TT/BCG/DPT/Hep B} = \frac{\text{Beneficiaries per month} \times 1.33\ast}{10} \]
- Similarly for OPV having a 20 dose vial,
  \[ \text{OPV} = \frac{\text{Beneficiaries per month} \times 1.33}{20} \]
- And measles packed in a 5 dose vial:
  \[ \text{Measles} = \frac{\text{Beneficiaries per month} \times 1.33\ast}{5} \]
- For Vitamin A, wastage taken is 10% and so a wastage factor of 1.11 applies as follows;
  \[ \text{VitA} = \left(\left(\text{monthly target of infants} \times 1 \text{ ml}\right) + \left(\text{monthly target of infants} \times 2 \text{ ml} \times 8\right)\right) \times 1.11\ast\]

In areas with biannual vitamin A supplementation rounds, the program managers may consider planning for only the initial dose of Vitamin A (in 9 months with measles) through the Immunization program.

Example:

Village Khusai, has a population of 1000, wherein headcount was undertaken in April 2012 and 40 children of age group 0-1 years & 25 pregnant women were identified. What would be the annual and monthly target of infants & pregnant women for the immunization services? Also estimate the Measles and TT vaccine requirement in doses and in vials for the above situation.

Annual target for infants = 40
Annual target for pregnant women = 25 * 2 = 50
Monthly target for infants = \(\frac{40}{12} = 3.3 \approx 3\)
Monthly target for pregnant women = \(\frac{50}{12} = 4.2 \approx 4\)

Estimating vaccine requirement in doses:
For Measles vaccine = 3 * 2 = 6
For TT = 4 * 3.5 = 14

Calculating the monthly vaccine requirement in vials:
For Measles vaccine = \(\frac{3 \times 1.33 = 0.79 \approx 1}{5}\)
For TT = \(\frac{4 \times 1.33 = 0.53 \approx 1}{10}\)
Step 7: Calculating the requirement of Syringes per month (in columns u, v and w#)

As for the vaccine used during the immunization sessions, proper calculation of syringes required is also necessary.

The calculation is as follows:

0.1 ml ADS = Beneficiaries for BCG × 1.1*

0.5 ml ADS = Beneficiaries for (TT + DPT + Hep B + Measles) × 1.1*

Reconstitution Syringes = (BCG + Measles vials) × 1.1*

*For Syringes = 10% wastage rate or 1.11 WMF (Wastage Multiplication Factor)

Note: With the introduction of auto-disable syringes, it is not possible to reuse syringes. However special provision has to be made to ensure their proper disposal.

Step 8: Making the Health worker work-plan or roster on the basis of injection load

The health worker roster/work-plan is the final outcome of the session micro planning process. This is more like a calendar of activities and can be used for monthly or quarterly (in this case) intervals.

On the basis of the injection load, the health worker calculates the number of sessions needed in each village/habitation. Usually, larger villages have more sessions than the smaller villages. The following table may be used for reference:

<table>
<thead>
<tr>
<th>Outreach sites</th>
<th>Fixed sites</th>
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<tbody>
<tr>
<td>• 1-24 injections = 1 session every alternate month</td>
<td>• 1-39 injections = 1 session every alternate month</td>
</tr>
<tr>
<td>• 25-50 injections = 1 session per month</td>
<td>• 40-70 injections = 1 session per month</td>
</tr>
<tr>
<td>• 51-100 injections = 2 sessions per month, etc</td>
<td>• 71-140 injections = 2 sessions per month, etc</td>
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</tbody>
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*For hard-to-reach areas with popn. less than 1000 = minimum of 4 sessions a year

For a busy CHC/RH, plan daily sessions.

The injection load is the average injections during a session based on the expected number of beneficiaries. If 25 infant are born each year in a given population, then there would be around 2 infants and 2 pregnant women for vaccination each month.

The number of injections to vaccinate one infant is 10 (1 BCG, 5 DPTs, 1 Measles, 3 Hep. B).

The number of injections to vaccinate one mother is 2. Total injections for two infants and 2 pregnant mothers are 10+10+2+2 = 24 injections per month.

In the final session plan/ANM roster,

• List all villages & hamlets in Sub-Center area in the same order as Step 1 (in column village)
• Write distance of village from the closest ILR (in column distance)
• List names of the AWW and ASHA (in column AWW, ASHA)
• Write the monthly injection load per village (in column injections per month)
• Write names of community influencers and volunteers who would help in social mobilization for immunization

The exact site of the session and the local timings (time, day of vaccination) would be determined by the health worker in consultation with link workers and community members. These should also be mentioned in the micro plan.
Step 10: map making

Prepare a map of the Sub-Center area including all villages and hamlets with their:

- Total population and annual target infants
- Anganwadi Centers and session sites
- Distance from the ILR point and transport mode
- Landmarks e.g. Panchayat, school, roads etc.
- Sessions days
KNOWLEDGE TEST

1. You are to plan an immunization session for a village with a total population of 3000 where the number of pregnant women based on the actual head count is 48. For estimating the monthly beneficiaries of pregnant women will be done by using the formula
   a) \( \frac{48 \times 2}{3000} \times 100 = 3.2 = \text{approx 3} \)
   b) \( \frac{96 \times 10\%}{12} = 76.8 = \text{approx 77} \)
   c) \( \frac{48 \times 2}{12} = 8 \)
   d) \( \frac{48}{2} = 4 \)

2. A village has a population of 2000 (actual head count) and the annual target of infants (actual head count) is 65. What is the monthly target of infants?
   a) 5.5
   b) 6
   c) 30
   d) 7.5

3. The requirement of monthly BCG vaccine in vials in a village for beneficiaries whose annual target of infants is 44, will be?
   a) 1
   b) 0.5
   c) 2
   d) 2.5

4. Wastage factor for DPT is
   a) 1.09
   b) 1.51
   c) 1.33
   d) 1.11

5. For an outreach site, in a village of 1600 population, the injection load per month is 60. As a program manager how many immunization sessions would you plan in a year?
   a) 1 session every alternate month
   b) 1 session per month
   c) 2 sessions per month
   d) 4 sessions in a year
6. During a head count of pregnant women in a village, 30 women have been identified. What is the monthly target for TT1 dose?
   a) 4
   b) 5
   c) 6
   d) 8

7. Which of the following should NOT be included while preparing a map of sub-centre area providing all villages and hamlets?
   a) Total population and annual target infants
   b) Anganwadi centres and session sites
   c) Distance from the ILR points and transport mode
   d) Landmarks e.g. Panchayat, school, roads, etc.
   e) Session days
   f) None of the above
D. Planning for Village Health and Nutrition days

12. Why village health and nutrition days?

Well planned and executed outreach health services provide the opportunity to incorporate several activities which can be delivered by a trained health worker during her/his visit to the outreach sites.

Health workers in rural areas usually serve in health sub centers which cater to a population of around 5000 persons. This area consists of several villages, one village with the sub center itself and others with Anganwadi Kendra’s (ICDS centers) or other session sites.

The Health worker’s typical plan should have fixed days in a month when she/he can provide a package of services related to health, nutrition and sanitation in each of these villages.

In many states of India, during the immunization outreach session sites, the health worker along with the ICDS worker and ASHA now provide an entire range of such services.

These opportunities are called village health and nutrition days.

13. What is the package of activities for VHND?

The package of activities during the village health and nutrition days include provision of certain services, discussion with the community on pertinent health, sanitation and nutrition issues, identification of cases that need special attention for appropriate action and collection of relevant data.

A) SERVICES TO BE PROVIDED:

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC (Ante Natal Checkups).
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.
- All eligible children are to be given vaccines against six Vaccine-preventable diseases.
- All dropout children who do not receive vaccines as per the scheduled doses are to be tracked, mobilized and vaccinated.
- Vitamin A solution is to be administered to children.
• All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to treat malnutrition.
• Anti-TB drugs are to be given to patients of TB.
• All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
• Supplementary nutrition is to be provided to underweight children.

B) ISSUES TO BE DISCUSSED WITH THE COMMUNITY:
• Danger signs during pregnancy
• Importance of institutional delivery and where to go for delivery
• Importance of seeking post-natal care
• Counseling on Essential New Born Care (ENBC)
• Registration for the Janani Suraksha Yojana (JSY)
• Counseling for better nutrition
• Exclusive Breastfeeding
• Weaning and complementary feeding
• Care during diarrhea and home management
• Immunization and its importance
• Care during acute respiratory infections
• Prevention of malaria, TB, and other communicable diseases
• Importance of safe drinking water
• Village Health Nutrition Days
• Personal hygiene
• Household sanitation
• Education of children
• Dangers of sex selection
• Age at marriage
• Information on RTIs, STIs, HIV/AIDS and prevention
• Disease outbreak
• Disaster management

C) IDENTIFICATION OF CASES THAT NEED SPECIAL ATTENTION:
• Identify children with disabilities.
• Identify children with Grade III and Grade IV malnutrition for referral
• Identify severe cases of anaemia.
• Identify pregnant women who need hospitalization.
• Identify cases of malaria, TB, leprosy, and Kala Azar.
• Identify problems of the old and the destitute.
• Pay special attention to the SC, ST, the minorities, and the weaker sections of society.
D) COLLECTION OF DATA:
- Compile data on the number of children with special needs, particularly girl children with disabilities.
- Report outbreaks of disease.
- Report/audit deaths of children and women.
- Compile data pertaining to the SCs, the STs, the minorities, and weaker sections of society that need services.

14. What additional resources need planning for during VHNDs?

Skills: For the proper implementation of VHNDs, the most important component is to ensure that the health workers and the village link workers (ICDS workers and ASHAs) have the requisite skills. This includes health worker skills for antenatal and postnatal checkups, haemoglobin and urine tests, identification of danger signs for appropriate action, data management and most importantly effective communication. Likewise the ICDS worker should be able to measure weight, monitor growth and counsel on nutrition. The ASHA should have her own set of skills for effective mobilization, communication and counseling.

Time and space: With a large range of services and activities to be provided, there is need for proper management of both space and time to ensure quality. The health worker should be discouraged from arriving late and leaving early and encouraged to spend time in providing services and counseling. The limited space in the Anganwadi centers also needs to be properly utilized ensuring privacy during antenatal and post natal check-ups and enough area for other services and waiting.

Instruments, equipment, and furniture
- Weighing scale-adult, child
- Examination table
- Bed screen/curtain
- Haemoglobin metres, kits for urine examination
- Gloves
- Slides
- Stethoscope and blood pressure instrument
- Measuring tape
- Foetoscope
- Vaccine carrier with ice packs

If these items are not available, their provision could be arranged by using the untied fund of Rs 10,000/- available with the ANM or with the VHSC. These items should be kept under the safe custody of the ASHA worker.

Logistics
- Supplies such as vaccines, IFA tablets, Vitamin A, condoms, OCPs,
- (ECPs), ORS, and Cotrimoxazole, Zinc
- Anti-helminthic drug
- Chloroquin
- Anti-TB drugs
- Paracetamol
- Stains for fixing BF
- AD syringes in sufficient quantity
- IEC material for communication and counseling
- Hub cutters, red and black bags.

**Community involvement:** Without community involvement it is impossible to carry out an effective VHND. Community is not only needed during the discussion meetings, but should be encouraged to own the entire range of activity. The day should be seen as a day of festivity where community is responsible for the organization of all the activities, is keen to provide resources and proud to own the results.

Active community members should be identified and their roles defined if possible in the VHND plan.

**Supervision:** Whenever Village Health and Nutrition days are organized, there should also be a workable plan for effective supportive supervision. Supervisors should be able to support the VHND by overseeing and helping the workers as well as interacting with the community. It is helpful if medical officers also plan their area visits during VHNDs; associated health check-ups by doctors would go a long way in making the activities more acceptable and effective.
**Knowledge Test**

1. A health worker in a rural area usually in a sub-centre caters to a population of
   a) 3000
   b) 5000
   c) 7000 – 10000
   d) 1000

2. On VHND, all dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated. Dropout children are those
   a) Children who receive one or more vaccination but do not return for the subsequent immunization
   b) Who do not utilize immunization services for reasons including lack of geographical access
   c) Who have been missed by the health worker on the immunization day
   d) None of the above

3. Some of the important activities for a Village Health & Nutrition Day includes
   a) Services to be provided to the community
   b) Issues to be discussed with the community
   c) Collection of relevant data and reporting
   d) None of the above
   e) All of the above

4. Village Health and Nutrition Days are held
   a) Depending on the availability of the beneficiaries
   b) On any day depending on the free time availability by the health worker or beneficiaries
   c) On fixed days
   d) None of the above
E. Planning for Special areas

15. What areas need special planning?

All areas for which planning of regular immunization services is not possible needs special planning. Once health worker-wise plans are prepared and all areas with regular outreach sessions identified, the remaining areas must be re-listed to plan for other strategic approaches.

These may be one or more of the following types of areas:

- Hard to reach areas
- Un served or underserved areas / Areas with shortage of health workers
- Urban areas, specially slums
- Migratory populations including temporary harvesters, brick kiln workers and construction laborers in large construction sites
- Unsafe to travel areas

16. What are the processes involved in planning for special areas?

Some of the processes are discussed below and are suggested as different ways in which to work out a plan for the special areas.

- Identify the obstacles:
  - Find the exact nature of the situation which has prevented regular sessions from taking place.
  - This could range from problems of access, mobility, manpower, time or just the lack of will.
  - Identifying the main cause will also help in finding the appropriate solution.
- Learn from past experiences
  - Find out whether there has been any attempt to provide services in the past
  - What are the lessons that can be learnt from these attempts?
- Look for opportunities
  - Are any other types of service being provided in these areas? How has this been possible? Is there something to learn from these services?

Some examples:

- The Polio supplementary immunization activities has shown how vaccines can be reached to difficult areas by means of using a variety of transport mechanisms like boats, tractors, labor; sometimes using a series of such means to reach one spot. Would it be possible to use these mechanisms to provide other vaccines and services?
- The ICDS department has extended its services to a large number of urban slums. It would be possible to identify these centers as session sites.
- Some faith based organizations and NGOs have health posts in difficult to reach areas. Would providing vaccines and some supplies to them ensure vaccination and other services reach these areas?
• Keep seasons and local situations and events in mind
  – Keep in mind the best seasons to reach these areas. Activities to provide services to these areas are best planned in these seasons.
  – Presence of migratory populations are also season dependent, they usually follow a similar migratory trend each year. It is important to understand this e.g. season for brick-making, harvesting.
  – Is there a time of truce between two fighting groups? Can this be utilized to provide health and humanitarian services?
• Utilize local knowledge and resources
  – It is always beneficial to gather local knowledge and resources. Is there a less dangerous route that can be taken to reach the areas? Can local people provide some form of transport? Can the local persons help in mobilizing the community and providing a place for the activity?
• Work out additional resources
  – Additional resources needed for carrying out activities in special areas also need to be worked out in advance.
  – Funds for alternate vaccinators, alternate means of vaccine delivery (mobility and transport), paid mobilizers and even immunization weeks may be available with the program management units and health societies.
• Be flexible
  – Different areas may need different plans; there is no standard plan that fits all situations. It is important to be flexible and work away from accepted rules. Some examples are:
  – Where there is a shortage of health workers in areas, instead of carrying out vaccination during the regular “Immunization/VHNday” (such as a Wednesday), another day can be selected when health workers can be sent out to provide services in these unreached areas.
  – When planning in monthly cycles the 5th (fixed) day of the month is often missed, such as a 5th Wednesday. Health workers usually do not have any planned session for such days and these days can be utilized for undertaking special activities.
  – It may be easier to supply vaccines and logistics to a hard to reach site from another administrative area rather than the one to which it is regularly attached.
• Plan for at least 4 visits in a year
  – This would help in giving at least four opportunities for vaccination to any newborn cohort to achieve a full immunization status by the end of one year.
• Combine with other services and interventions
  – Consider what other interventions can be added to immunization when the area is infrequently visited, e.g. malaria control, vitamin A supplementation, anti-parasitic control, Zinc and ORS.
  – A medical doctor in the team would also help to identify and give appropriate management for sick persons.
• Have a written plan
  – Ensure that the plan is in writing and communicated timely for everyone concerned
  – The plan should have the following
» **Where:** The areas to be covered, their population and distance (in kilometers and travel time) from the main health center

» **When:** The day and date of the activity, preferably also the time and location of the site

» **Who:** The name of the team leader, vaccinators, supervisors, local mobilizers and local help with their roles defined.

» **How:** The means of transport worked out in detail. A local guide if necessary.

» **How much:** All the logistics and supplies needed, calculated with sufficient buffer.

» Refreshments and drinking water.

> Have we written down all that we have planned for?

» Communicate it to all concerned, especially to the community members themselves so they are available to receive the services, and prepare for it timely.

» Adjust for any last moment changes/problems

» Such as last moment absenteeism

» Sudden change of weather and need for subsequent change in route plan

17. **What are mobile teams and how can they be used?**

In almost every state there are areas that cannot be reached regularly throughout the year. This may be due to many factors, including remoteness, and seasonal factors such as flooding in the rainy season. Under these circumstances, using mobile teams may be the best way to provide immunization services.

Mobile teams constitute sending a small health team with adequate supplies and appropriate mobility arrangement to provide immunization and other outreach services in villages and areas which are otherwise difficult to reach.

Mobile teams provide outreach services but work like a small regular campaign. They can visit several sites over the course of one or more days during the dry season. Since mobile teams will only have a few days in which to do their work, careful planning is needed.

Mobile teams will need extra resources. Therefore, planning should be carried out in consultation between health facility, district and other levels. Sample mobile team schedule for the year.
Villages | Target beneficiaries | Injections per year (target beneficiaries $\times$ 7) | Workload per session | Other interventions planned | Planned dates | Vehicle needs | Staff needs |
---|---|---|---|---|---|---|---|
S, T, W, X | 90 | 630 | 158 injections per mobile team visit | Vit. A, Malaria bednets, ORS packets and zinc medicines | 6 Jan., 5 Mar., 4 May, 6 Oct. | PHC Vehicle till river x, followed by hired boat and tractor of village headman | Medical officer+ Health Workers + driver |

Table above shows an annual schedule for reaching all four villages S, T, W, X four times a year.

18. **What are special immunization drives/ immunization weeks or PIRI?**

A series of immunization days or weeks planned for intensified activity in areas with poor coverage over a few months has shown to help in improving the immunization coverage. These are also called catch-up rounds or Periodic Intensification of Routine Immunization (PIRI).

Usually all areas which are hard to reach, have irregular sessions or have poor coverage, should be identified and micro plans should be prepared to send immunization teams there over a period of several days (usually 5-7). With intensified publicity and supervision along with the provision of any additional resources it is possible to use these opportunities to rapidly improve the immunization coverage.

Four rounds of these special drives are recommended in succession with a period of at least 28 days between each round.

19. **How to Plan for immunization services in urban areas?**

High population density, poor sanitation and poor nutrition often found in urban areas, lead to higher transmission of diseases, infection of younger children and higher mortality.

Providing immunization services in crowded urban areas differs from rural areas for many reasons, including the following:

- Poor primary health care infrastructure in some urban areas.
- High mobility of the resident population.
- The existence of “illegal” settlements that are not officially recognized by the government.
- The existence of marginalized populations (religious or ethnic minorities, refugees).
- Absence of information on the size of the population living in “slum” areas.
- Inadequate government planning and budget to provide primary health care services to these areas.

The key to provision of adequate immunization facilities to the urban areas is regular, high quality, uninterrupted service at accessible delivery points.

Urban immunization services may be operationalized in the following way:

1. Fixed site, fixed time provision of services. This should include:
   - All fixed sites including Aganwadi centres, dispensaries, clinics and maternity homes in the public sector.
2. Communication through ICDS workers, health workers, NGOs active in the area, print media, television, radio about the following:
   • The timing of local immunization services;
   • Local service delivery points;
   • The vaccines and schedule of immunization;
   • The benefits of immunization.

3. Urban outreach: expanding the network of urban service provision points from the health facility:
   • Establish contact with the local leader and obtain support.
   • Estimate size of population and frequency of sessions (same as with rural areas).
   • Set up a site in every urban slum, with one or two trained vaccinators, to provide immunization services on a regular (weekly or monthly) basis.
   • Use the same principles for creating a session plan and work plan (described in previous section) for the expanded network of urban outreach.
   • Plan location of sites, frequency, and timing of service, to suit the local population.
   • Communicate time and dates of sessions to the community (using existing channels in the community like loudspeakers, religious or mothers’ groups etc.).
   • Ensure a regular uninterrupted service to gain the trust and cooperation of the community.
1. Which of the following are types of special planning area?
   a) Un served or underserved areas
   b) Urban slums
   c) Areas with migratory population
   d) All of the above
   e) None of the above

2. Select a process which is not involved in planning for special areas.
   a) Keeping seasons and local affairs in mind
   b) Cancelling regular sessions as planned
   c) Be flexible in working away from accepted plans
   d) Ensuring that the plan is in writing and communicated timely to everyone concerned

3. As a Health Manager, you have to plan immunization sessions for hard to reach areas. The plan is to cover an area with at least 4 visits in a year. The reason for 4 visits can be
   a) It gives opportunities for vaccination to any newborn cohort to achieve a full immunization status by the end of one year
   b) It has been provided in the immunization guidelines to conduct 4 visits to such areas
   c) Because the trend of the migratory population changes every four times in a year
   d) Additional resources are provided to conduct these activities

4. Areas with poor immunization coverage are covered with series of immunization days or weeks with intensified activities. These sessions are called
   a) Special Immunization drives
   b) Periodic Intensification of Routine Immunization
   c) Catch Up Rounds
   d) All of the above

5. Which of the following are included in the operationalization of urban immunization services?
   a) Expansion of the network of urban service provision points from the health facility
   b) Communication through all health workers, NGOs, print media, television and radio about the timing of services, local service delivery points, vaccines & immunization schedule and its benefits
   c) Provision of fixed site, fixed time of services
   d) All of the above
   e) None of the above
**F. Supplementary plans**

**20. What are supplementary plans for immunization?**

Apart from session-wise micro plans, there is need for plans at the vaccine storage and management levels to ensure quality of the immunization program.

The following plans made at the first and higher management levels are recommended for this purpose:

- Supervisory plans
- Vaccine movement plans
- Social mobilization and communication plans
- Rosters
- Maps
- Budgetary plan

**21. How are supervisory plans made?**

For supervisory plans the following steps can be followed:

- Identify all the supervisors available for undertaking field visits to session sites. Supervisors from all stakeholder agencies should be identified.
- Divide health workers’ areas amongst them.
  - Ensure no more than 3-5 areas per supervisor.
  - Also ensure there is at least 1 supervisory visit planned for every session.
  - Avoid duplication of area among supervisors.
  - A map showing supervisory areas would also help.
- Ensure all supervisors are trained, have mobility arrangement and have standard supervisory checklists.
- Once supervisory plan is finalized, this should be communicated in written to all supervisors.
- Ensure the name of the supervisor is included in the Health workers’ session/ work plan and roster. This helps in ensuring that every health worker knows who his/her supervisor is.

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**Supervision Plan of Dinapur CD Block**

<table>
<thead>
<tr>
<th>Name of Sub-Centres</th>
<th>Name of PHC Area</th>
<th>Name of Supervisors</th>
<th>Name of M.O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hetanpur</td>
<td>Hetanpur</td>
<td>A K Rajak NMA APHC Sahpur</td>
<td>Dr AK Ohja</td>
</tr>
<tr>
<td>Ganghara Hawaspur</td>
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<tr>
<td>Nurpur Mubarkpur Jamasut</td>
<td>Shahpur</td>
<td>Rajesh Kumar Rai HE APHC Sahpur</td>
<td>Dr Sunita Kumari</td>
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<tr>
<td>Danapur CHC Jamaluddin chak Rupaspur</td>
<td>Khagaul</td>
<td>Arvind Kr HE APHC Sahpur</td>
<td>Dr Snehlata Singh</td>
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<tr>
<td>Usri Shikarpur Rukanpura</td>
<td>Danapur</td>
<td>Urmila Devi HQ L.H.V</td>
<td>Dr Anita Singh</td>
</tr>
</tbody>
</table>

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**Supervision Plan Map**

Diagram showing supervision areas and supervisors' names.
22. What are vaccine delivery plans?

Workable plans are needed to ensure vaccines and other logistics are delivered to the outreach sites from the point of storage (ILR point). Alternate vaccine delivery mechanisms are encouraged for this activity rather than arranging for health workers to transport the logistics themselves.

Alternate vaccine delivery mechanisms should ensure the following:

- Right time: Timely lifting up of all vaccines and logistics and delivery before scheduled start of outreach session.
- Right materials in right quantities and conditions: make sure the required quantities of vaccines and logistics are transported to the session site in good condition.
- Appropriate, affordable and feasible for local conditions; ensuring factors such as local terrain, conditions and availability of reliable manpower and appropriate vehicles.
- Apart from delivery of vaccines and other VHND logistics, these alternate systems are also be used to return unused vaccines and logistics, materials for waste disposal and reports from the outreach session.

While planning for vaccine delivery the following details are to be noted:

- Person responsible for vaccine delivery
- Mode(s) of transport, including vehicle registration number
- Routes to be used
- Location of session sites where logistics are to be delivered, and names of concerned health staff at each site
- Distance in kms and time (starting to reach) from ILR point to each session sites

23. What are social mobilization plans?

An important part of the outreach program is to ensure beneficiaries turn up at the session site. To ensure this, there must be strategically planned communication and social mobilization activities.

It is helpful to put these plans on paper (or computer) noting micro-details of each activity planned for effective communication and mobilization. While communication and social mobilization is dealt in a separate module, it is helpful to identify key elements of communication that need to be included in all basic plans. These are:

- Name of the key mobilizers for each session such as the ASHA and the ICDS worker
- Name of community representative, influencer or VHSC member involved in community mobilization
- Dates for community meetings, including VHSC meetings and mothers' meetings
At the ILR point and the various management levels there should be plans for utilization of all communication materials received, e.g.
- points where posters and banners are to be put-up,
- forums and places where handouts can be distributed,
- routes where miking and announcements are to be undertaken
- community congregation sites where street plays and film shows can be arranged

All the above can feature in a separate social mobilization plan which is planned out strategically according to need and effectivity of each communication method.

### Sample Communication Plan

<table>
<thead>
<tr>
<th>Sub-center</th>
<th>Problem Description</th>
<th>Reasons</th>
<th>Community Involvement Activity</th>
<th>Participants</th>
<th>Responsible Person</th>
<th>Resources Needed</th>
<th>Time-frame</th>
<th>Monitoring Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthurna</td>
<td>Priority 1</td>
<td>55% left-outs (69 of 125 infants)</td>
<td>Session time and place not convenient</td>
<td>Meeting with NGOs and community for joint planning of sessions (times and places)</td>
<td>Community mobilizer, HW, community leaders, NGOs, TBA</td>
<td>Refreshments</td>
<td>Next one month</td>
<td>Minutes of meeting and revised session time and place</td>
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<tr>
<td>Kushalgarh</td>
<td>Priority 2</td>
<td>42% dropouts (90 of 212 infants)</td>
<td>Poor tracking</td>
<td>Train HW, AWW and ASHA in identifying and tracking dropouts</td>
<td>HW, AWW, ASHA, Supervisor</td>
<td>MO</td>
<td>Next monthly meeting</td>
<td>Coverage monitoring chart</td>
</tr>
<tr>
<td>Jhalod</td>
<td>Priority 3</td>
<td>43% dropouts (66 of 154 infants)</td>
<td>Coincidental AEFI in the village</td>
<td>Community Level Meeting and Street Play on safety of vaccines</td>
<td>AWW, ASHA, HW, NGOs, community leaders</td>
<td>PHC Health Extension Educator, Supervisor, MO</td>
<td>Next two month</td>
<td>Coverage monitoring chart</td>
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</table>

### 24. What is a roster?

While a complete micro plan may be extensive with several pages having details of each activity, time, place and person; for day to day usage, a more comprehensive list, preferably in one page or table is needed. This may not contain all the details, but would incorporate the most important information. Such a table or list is called a roster.

While preparing a roster, ask the following questions
- Who are the persons requiring regular information about the filed activities?
- What are the key information they need?
- How can this information be available in a single list or table?
- How can it be easily available?
- Where can it be displayed for easy day-to-day use?

Once prepared, the roster can be displayed at a well-known location for daily use. A hand held copy may also be useful.
### 25. What is the use of maps?

Maps are helpful tools to present information geographically. Immunization maps can be used to portray the following:

- **Immunization session sites**: in terms of location of ILR point, fixed, outreach and mobile sessions; days of activity: areas of health workers
- **Vaccine delivery routes**: distances, modes of transport, timings
- **Supervisory areas**: distribution of supervisory areas

<table>
<thead>
<tr>
<th>Name of Health Worker</th>
<th>Name of Supervisor</th>
<th>Name of Courier</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
<th>Session 7</th>
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<td>Manib Ansri</td>
<td>Kesw Singh</td>
<td>Week</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
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<td>Abgila</td>
<td>Tejpura</td>
<td>Kansopur</td>
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<td>Saroti/ Siyarampur</td>
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<tr>
<td>Name of Health Worker</td>
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<td>Name of Courier</td>
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<tr>
<td>Manorama Kumari / Usha Kumari</td>
<td>H E Ajay Singh</td>
<td>Sidhnath Singh</td>
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<tr>
<td>Village/Area</td>
<td>Koriyam</td>
<td>Jwahar Bigha</td>
<td>Banawli Bigha</td>
<td>Santawan Bigha</td>
<td>Koriyam Chawki</td>
<td>Bara</td>
<td>Dirpal Bigha</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Health Worker</td>
<td>Name of Supervisor</td>
<td>Name of Courier</td>
<td>Session 1</td>
<td>Session 2</td>
<td>Session 3</td>
<td>Session 4</td>
<td>Session 5</td>
<td>Session 6</td>
<td>Session 7</td>
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<tr>
<td>Sangita Kumari</td>
<td>Rajbanti Mehta</td>
<td>Umesh Singh</td>
<td>Week</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Day</td>
<td>Wed</td>
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<tr>
<td>Village/Area</td>
<td>Motha</td>
<td>Rojapar</td>
<td>Mokari</td>
<td>Mhadalit Rajapar</td>
<td>Moniya Bigha</td>
<td>Motha</td>
<td>Motha</td>
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</tr>
</tbody>
</table>
**Knowledge Test**

1. What are the supplementary plans for immunization?
   a) A session plan of village and urban vaccination areas made by local health worker in consultation with the village link workers
   b) A health worker’s typical plan to incorporate several activities which can be delivered to the outreach sites
   c) A plan where all areas with regular outreach sessions are identified first and the remaining areas are re-listed to plan for other strategic approaches
   d) All additional plans, apart from the session-wise micro plans, prepared at the vaccine storage and management levels to ensure quality of the immunization program

2. For which activity is Alternate Vaccine Delivery mechanism is encouraged?
   a) For the delivery of vaccines and other logistics to the outreach sites from the point of storage (ILR point)
   b) For redistributing areas among health workers so as to keep equity and feasibility
   c) For sending a small health team with adequate supplies and appropriate mobility arrangement to provide immunization
   d) For identifying villages/areas with pockets of left out beneficiaries

3. The objective of preparing a Social Mobilization plan is
   a) To ensure factors such as local terrain, conditions and availability of reliable manpower
   b) To ensure equity and uniformity in work load distribution while planning
   c) To ensure all beneficiaries turn up at the session
   d) To ensure that the distribution of health workers is uniform and that some areas do not have several health workers at the expense of some unmanned areas

4. What is a roster?
   a) A extensive complete micro plan
   b) A single table form covering the most important information of a micro plan
   c) A single page with all the details of micro plan
   d) None of the above

5. A immunization map must comprise of
   a) Supervisory areas
   b) Immunization session sites
   c) Vaccine delivery routes
   d) None of the above
   e) All of the above
G. Tools for micro planning

Use of soft-ware tools

a. USAID-Immunization basics tool

A software tool, which is easy to follow and is yet comprehensive for planning of immunization activities, has been developed by Immunization basics in India. This is available in the internet at the following links:

http://www.immunizationbasics.jsi.com here the excel table can be downloaded from “Block level RI micro planning tool” and the guidelines are available at:

B. Bihar State Health Society micro planning tools

Software tool (in excel) to help in micro planning at block level was developed by State Health Society Bihar and Unicef. This comes with an operational guideline in Hindi giving a step-by-step approach to prepare a micro plan. Additionally, district level plans also exist where information from blocks can be consolidated for use at district level.

The software version and operational guidelines are available with Routine Immunization Cell, State Health Society, Bihar.
### 27. Checklists for micro planning

Once micro plans are prepared it is important to check-it to ensure no vital element has been left out. While checklists can be made as per requirement, below is a simple sample which can be used by program managers.

<table>
<thead>
<tr>
<th>MCHN Micro plan check list</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District name:</strong></td>
</tr>
<tr>
<td><strong>Block name:</strong></td>
</tr>
<tr>
<td><strong>Name of the assessor:</strong></td>
</tr>
<tr>
<td><strong>Date of assessment:</strong></td>
</tr>
<tr>
<td><strong>1 Formats completely filled and available</strong></td>
</tr>
<tr>
<td>1a Are all session plans completely filled and submitted sub-center wise</td>
</tr>
<tr>
<td>1b Are all sub-center area maps are submitted</td>
</tr>
<tr>
<td>1c Are all supervisory and vaccine delivery plans are submitted PHC wise</td>
</tr>
<tr>
<td>1d Are all PHC maps showing delivery routes are submitted</td>
</tr>
<tr>
<td><strong>2 Special plans for poor coverage areas</strong></td>
</tr>
<tr>
<td>2a Have special plans have been made for urban areas</td>
</tr>
<tr>
<td>2b Have special plans are made for difficult to reach areas</td>
</tr>
<tr>
<td>2c Have special plans have been made for seasonal areas</td>
</tr>
<tr>
<td>2d Have 2nd health workers been allotted in harder to reach areas?</td>
</tr>
<tr>
<td>2e Have male health workers been allotted in harder to reach areas?</td>
</tr>
<tr>
<td><strong>3 Reach</strong></td>
</tr>
<tr>
<td>3a Do the list of villages in Mp corresponds to comprehensive list from different sources</td>
</tr>
<tr>
<td>3b Are all hamlets names are mentioned in micro plan</td>
</tr>
<tr>
<td>3c Are all urban slums and areas are planned for</td>
</tr>
<tr>
<td>3d Are mines, kilns and migratory habitations are planned for</td>
</tr>
<tr>
<td><strong>4 Optimum workload</strong></td>
</tr>
<tr>
<td>4a Have all health workers have been de-lo ed on MCHN da s</td>
</tr>
<tr>
<td>4b Have all sessions have been planned as recommended injection load</td>
</tr>
<tr>
<td>4c Does an supervisor have more than 5 persons to supervise</td>
</tr>
<tr>
<td>4d Does the AVD planning ensure that deliver to the last point is before 8 am?</td>
</tr>
<tr>
<td>4e Does the AVD planning ensure that the available vehicle is not overloaded?</td>
</tr>
<tr>
<td><strong>5 Participatory planning</strong></td>
</tr>
<tr>
<td>5a Have Health workers themselves made the session plans?</td>
</tr>
<tr>
<td>5b Have village mobilizers and representatives been consulted?</td>
</tr>
<tr>
<td>5c Have supervisors been involved in making the supervisory plans?</td>
</tr>
<tr>
<td><strong>6 Micro plan dissemination</strong></td>
</tr>
<tr>
<td>6a Are copies of new micro plan available at</td>
</tr>
<tr>
<td>6b All health sub centers</td>
</tr>
<tr>
<td>6c All primary health centers</td>
</tr>
<tr>
<td>6d All Block CHCs /PHCs</td>
</tr>
<tr>
<td>6e District RCH office</td>
</tr>
<tr>
<td>6f District health Society</td>
</tr>
<tr>
<td>6g ICDS department block</td>
</tr>
<tr>
<td>6h Block Panchayat office</td>
</tr>
<tr>
<td><strong>7 Micro plan display</strong></td>
</tr>
<tr>
<td>7a Are rosters on dis la at all ILR points</td>
</tr>
<tr>
<td>7b Are ma s on dis la at all ILR points</td>
</tr>
<tr>
<td><strong>8 Micro plan use</strong></td>
</tr>
<tr>
<td>8a Has work started as er new micro plans</td>
</tr>
<tr>
<td>8b Since when ? in OO/MM/YY</td>
</tr>
<tr>
<td>8c Are plans available for rescheduling cancelled sessions?</td>
</tr>
</tbody>
</table>

**Remarks:**

**Signature with date of assessor**
28. How often does the micro plan need revision?

The following conditions should call for a revision in existing micro plans for immunization:

- Change in policy/strategy for immunization, e.g. immunization to be incorporated with other village health and nutrition activities.
- Change in manpower availability, e.g. second ANM in position in more health sub-centers.
- Change in manpower involved in vaccination, e.g. health workers transferred from one block to another, health supervisors transferred, any deaths.
- New areas added for vaccination, e.g. peri-urban growth, new areas for migratory habitations.
- Ideally it is good to revise the existing micro plans once a year.

Final Assessment

1. What is the recommended approach for planning?
   f) Starting from lower level to higher level (Bottom-up approach)
   g) Starting from higher levels and go to lower levels (Top down approach)
   h) Starting at all levels simultaneously
   i) None of the above

2. What is the lowest management unit in India where immunization sessions should be/are planned?
   a) Village
   b) Sub-centre
   c) PHC
   d) Block

3. The following are the objectives to keep in mind while preparing an Immunization micro plan. Which of the following is not true?
   a) Ensure equity and uniformity in work load distribution while planning, optimize available resources.
   b) Ensure planning for services other than immunization which can be combined.
   c) Prepare special area plans where regular activity is possible.
   d) Comprehensive session plans through participatory process.

4. In order to ensure Immunization coverage of all possible areas, within a SC one has to utilize information about the existing villages/areas from
   a) A single reliable source
   b) Sub-centre records
   c) ANMs working in SC
   d) Multiple sources (e.g. Census, previous records, polio micro plan, community survey)
5. The requirement of monthly BCG vaccine in vials in a village for beneficiaries whose annual target of infants is 30, will be?
   a) 1
   b) 0.33
   c) 2.04
   d) 0.64

6. You are supposed to plan an immunization session for a village with a total population of 2000 (based on actual head count) where the annual target of pregnant women based on the actual head count is 74. For estimating the monthly beneficiaries of pregnant women will be done by using the formula
   a) \( \frac{74 \times 100}{2000} = 3.7 \)
   b) \( \frac{74 \times 10\% \text{ of } 74}{12} = 45.8 \)
   c) \( \frac{74}{12} \approx 6.16 \approx 7 \)
   d) None of the above

7. For a fixed site, in a village of 2000 population, the injection load is 70. As a program manager how many immunization sessions would you plan in a year?
   a) 1 session every alternate month
   b) 1 session per month
   c) 2 sessions per month
   d) Daily sessions

8. Wastage factor of Vitamin A is
   a) 1.09
   b) 1.51
   c) 1.33
   d) 1.11

9. Monthly requirement of measles vaccine is calculated by using the formula
   a) \( \text{Beneficiaries per month} \times \frac{1.33}{3} \)
   b) \( \text{Beneficiaries per month} \times \frac{1.11}{10} \)
   c) \( \text{Beneficiaries per month} \times \frac{1.1}{2} \)
   d) \( \text{Beneficiaries per month} \times \frac{1.33}{5} \)
10. Wastage factor used for calculating required number of syringes is
   a) 1.33
   b) 1.10
   c) 1.11
   d) 1.1

11. On VHND, all dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated. Dropout children are those
   a) Who do not utilize immunization services for reasons including lack of geographical access
   b) Children who receive one or more vaccination but do not return for the subsequent immunization
   c) Who have been missed by the health worker on the immunization day
   d) None of the above

12. Certain activities during the VHND include
   a) Children under 5 years of age are given vaccine against vaccine preventable diseases
   b) All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services
   c) Issues such as exclusive breast feeding and prevention of communicable diseases are discussed with the community
   d) All of the above

13. Some of the important activities for a Village Health & Nutrition Day includes
   a) Services to be provided to the community
   b) Issues to be discussed with the community
   c) Collection of relevant data and reporting
   d) None of the above
   e) All of the above

14. Migratory population like brick kiln workers, construction laborers and slums in the urban areas are covered for immunization at
   a) Outreach session
   b) Fixed facility
   c) Mobile strategy
   d) Village Health and Nutrition day.

15. Important processes involved in planning for special areas include all of the following except
   a) There is a standard plan that fits all. It is important to work from the accepted areas and rules
   b) Identifying obstacles such as access, mobility, manpower, time or just the lack of will
   c) Learning from the past experiences
   d) Combining other services and interventions such as a medical doctor in the team would also help to identify the sick person and give appropriate management
16. What is the difference between left out and drop outs?
   a) Left out are those who have been missed by the health workers for immunization and dropout are those who do not utilize the services
   b) Those children and women who do not utilize the immunization services for reasons including lack of geographical access are known as left out and dropout are those who had receive one or more doses and have not returned for the successive doses
   c) Left out are those who had receive one or more doses of vaccination but have not come back for the successive doses and drop outs are those who had been missed out by the health worker during the immunization session
   d) None of the above

17. Which of the following are included in the operationalization of urban immunization services?
   a) Expansion of the network of urban service provision points from the health facility
   b) Communication through all health workers, NGOs, print media, television and radio about the timing of services, local service delivery points, vaccines & immunization schedule and its benefits
   c) Provision of fixed site, fixed time of services
   d) All of the above
   e) None of the above

18. For which activity is Alternate Vaccine Delivery mechanism encouraged?
   a) For the delivery of vaccines and other logistics to the outreach sites from the point of storage (ILR point)
   b) For redistributing areas among health workers so as to keep equity and feasibility
   c) For sending a small health team with adequate supplies and appropriate mobility arrangement to provide immunization
   d) For identifying villages/areas with pockets of left out beneficiaries

19. The benefit of preparing a Social Mobilization plan is:
   a) To ensure factors such as local terrain, conditions and availability of reliable manpower
   b) To ensure equity and uniformity in work load distribution while planning
   c) To ensure beneficiaries turn up at the session
   d) To ensure that the distribution of health workers is uniform and that some areas do not have several health workers at the expense of some unmanned areas

20. In which condition an existing micro plan for immunization should be revised?
   a) Change in policy/strategy
   b) Change in manpower availability
   c) New areas added for vaccination
   d) All of the above
Useful references

- Immunization in Practice, A practical guide for health staff WHO/IVP 2004
  - [http://www.who.int/vaccines-documents/PDF-Cat/IIIPmodules.pdf](http://www.who.int/vaccines-documents/PDF-Cat/IIIPmodules.pdf)
- Immunization handbook for Medical officers Dept of Health and Family Welfare, Govt. of India 2009
  - [http://www.whoindia.org/LinkFiles/Routine_Immunization_Immunization_Handbook_for_Medical_Officers_.pdf](http://www.whoindia.org/LinkFiles/Routine_Immunization_Immunization_Handbook_for_Medical_Officers_.pdf)
- Immunization essentials: A practical field guide. USAID 2003
- Monthly Village health and nutrition days; Guidelines for AWWs/ASHAs/ANMs/PRIs. Feb 2007, MOHFW, GoI
### Facilitators’ Guide: Health managers’ handbook

<table>
<thead>
<tr>
<th>Section</th>
<th>Method (time)</th>
<th>Tool</th>
</tr>
</thead>
</table>
| **2A: Basics in micro planning**  
- need  
- process  
- planning unit  
- types of sites  
- who prepares micro plans  
- objectives for micro planning  
- steps | Question placed by facilitator to group and group members answer, facilitator wraps up adding points that were missed or by making the participants read the answers *(15 mins)* | Questions and answers in the module |
| **2B: Equity in micro planning**  
- Ensuring equity | **Game:** Take 3-4 participants and make them to hold different corners of a piece of paper. At the word “PULL”, from the facilitator all the participants will pull the piece of paper. The larger pieces of paper will be pulled by participants who put in more strength indicating that more influential people get a more generous part of the resources!!  
Tell the managers that this is a usual outcome in real life. *(10 mins)*  
**Group Discussion and presentation:** Ask them to work in groups and arrive at practical steps to identify underserved groups (for group A) and ensure weaker sections of society receive adequate attention and resources from the health service providers, particularly for immunization services (group B)! The facilitator will wrap up filling in the points missed by both groups. *(50 mins)* | **For the game:** Piece of paper: a sheet of old news paper would do.  
**For the group discussion:** Points outlined in the module may be used. |
| **2C: Session micro planning**  
- Steps for preparation of session plan | Presentation and format reading for each step involved in micro planning followed by exercise *(1 and ½ hr)* | Presentation on micro plan preparation.  
Exercise on logistics calculation. |
| **2 D: VHND**  
- Why  
- Services provided (1)  
- Topics for discussion with community (2)  
- Identification of special cases (3)  
- Collection of data (4)  
- Planning for VHND  
  - Skills  
  - Capacity building  
  - Site, date, time  
  - Instruments  
  - Arrangements  
  - Logistics  
  - Community involvement  
  - Supervision | **Short discussion:** Difference between outreach immunization session and VHND with whole group *(10 mins)*  
**Group work followed by presentation:** *(25 mins)*  
Group A (to take up points 1 & 3)  
Group B (to take up points 2 & 4)  
**Role play:** *(25 mins)*  
Planning for VHND session  
Interaction between Medical officer, supervisor, store in charge, PRI member and manager. They are to discuss the training of health workers, logistics, community involvement, supervision, site, date, venue of the next VHND. | **For the group discussion and role play:** Points outlined in the module may be used. |
<table>
<thead>
<tr>
<th>Section</th>
<th>Method (time)</th>
<th>Method (time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 E Planning for special areas</td>
<td><strong>Facilitator enumerates:</strong> special areas types with participants (5 mins)</td>
<td>Chart paper and marker pens</td>
</tr>
<tr>
<td>and situations</td>
<td><strong>Group work:</strong> divide participants into two groups (A) Urban area with only 1 public health facility offering vaccination services and (B) Hard to reach area with seasonal access. Ask groups to enlist the possible problems and identify solutions to carry out vaccination services in these areas. Ask both the groups to develop a written action plan. (25 mins)</td>
<td></td>
</tr>
<tr>
<td>2 F Supplementary plans</td>
<td>Demonstration of relevant state specific formats and maps and short discussion on each format/map led by facilitator. (10 mins)</td>
<td>Formats for supervision, vaccine delivery, social mobilization, roster, PHC level maps as used by the state.</td>
</tr>
<tr>
<td>2 G Tools</td>
<td>Demonstrate through any tool that the state is using (10 mins)</td>
<td>Tools as used by the state</td>
</tr>
<tr>
<td>2 H Checklist/ timelines/ state</td>
<td>Demonstrate through any tool that the state is using, read guidelines and timelines, ensure every participant gets a copy (10 mins)</td>
<td>Format, guidelines etc. used by state</td>
</tr>
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<td>level guidelines and instructions</td>
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</table>