Detailed list of activities at RI microplan development

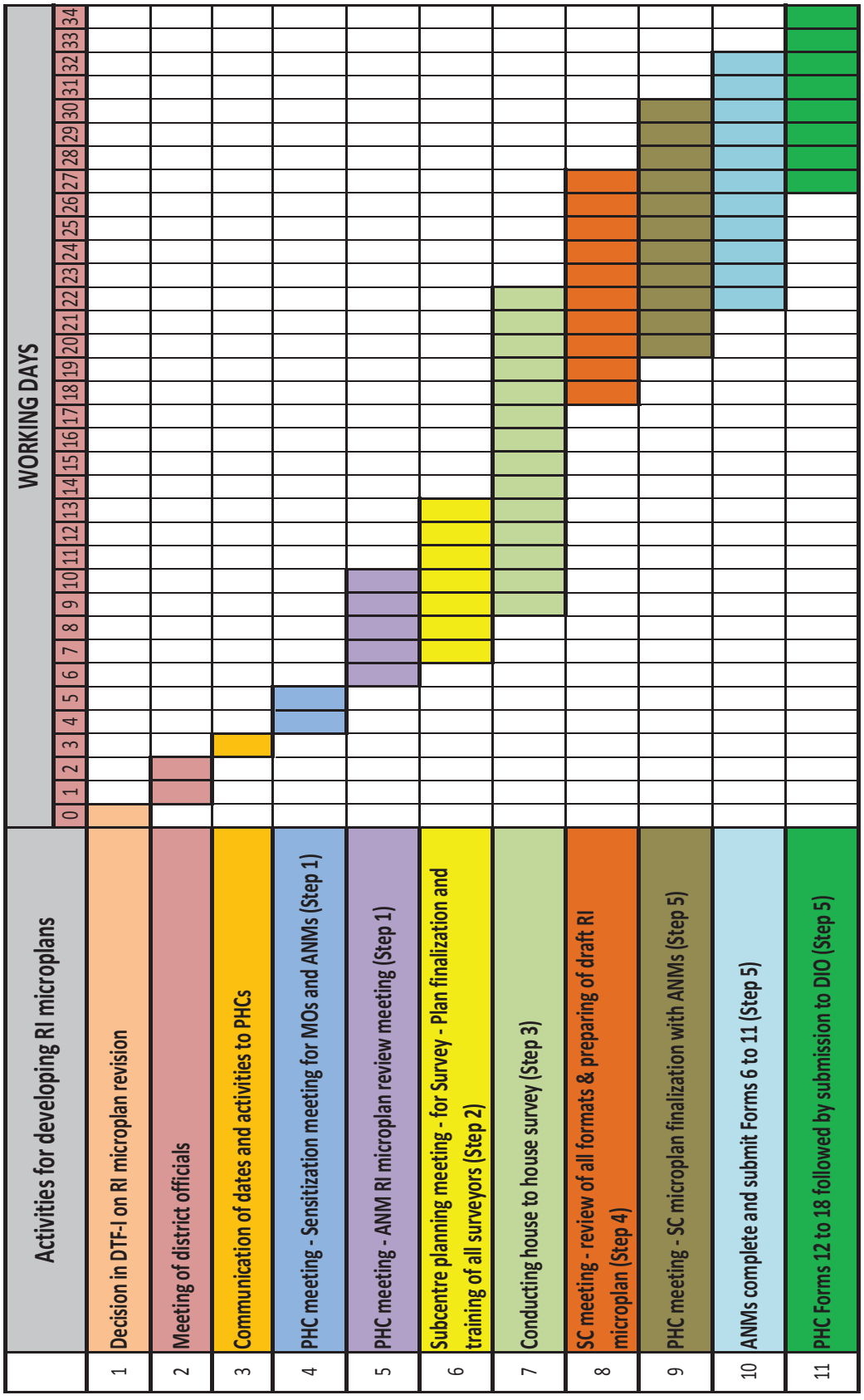
To simplify the process of developing RI microplans, Table 3.3 below enlists in detail the activities at each step. This table can also be used as a checklist to review the process and guide the actions of medical officers and ANMs.

Table 3.3. Steps and activities for RI microplanning

Steps	Activities
STEP 1 **Block PHC/UHC meeting–** ➢ Orientation meeting ➢ ANM RI review meeting- review of existing microplans & inclusion of all areas	• Confirm area demarcation of subcentres • Confirm area demarcation among ANMs, especially in subcentres where more than one ANM is posted. • Generate a master list of villages/areas, Include ALL areas in RI microplan • Record sub centre wise information • Use data on SC performance • Conduct training of ANMs for area survey • Prepare SC plan for head count / survey
STEP 2 **Planning for SC level head count survey and training of ASHA/AWW/ Link worker/Surveyor**	**MO to decide venue of meeting– at each SC or if at PHC then conduct with only 2 to 3 SC combined at a time** • Confirm area demarcation between ASHA, AWW /LW/ surveyor • Create working maps for each area • Conduct training to undertake head count & generate beneficiary list • Plan to walk through areas to ensure clear area demarcation/ HRA identification
STEP 3 **House to house survey** village/ward level -ASHA/AWW/Surveyor	• As per the plan, the ASHA/AWW/LW/Surveyor with assistance from mobilizers will conduct the area survey. This is NOT to be done on RI days. • During the survey ▪ Maximum of 25 to 30 houses should be covered per day. ▪ Collect information of pregnant women, infants and children. ▪ Survey to be completed in 7 to 10 days • Generate beneficiary list for the village/ward • Ensure monitoring of the process by ANM , ICDS supervisors, Sector Medical Officer, any other

STEP 4 **Review & consolidation of the Sub centre microplan**	**Conduct review meeting at SC – involving AWW /ASHA / Link worker / surveyor. Sector MO oversight will be beneficial.** **ANM to:** • Review completeness of all formats of the area • Review the master list of areas in the SC • Review the area of demarcation • Review the number of HRA in the SC • Review lists of identified beneficiaries • Develop SC RI microplan for finalization • Develop community mobilization plan for each session site and sub centre area
STEP 5 **Review and finalization of SC plans and development of final block PHC plan**	• Finalization of area demarcation of ANMs • Finalization of areas and HRAs in all SC microplans • Review of all SC formats and approval of microplans • ANM to complete filling of all SC formats and submit • Develop the session due list for RI sessions • Ensure availability of beneficiary due listing for all sessions • SC Maps availability • Development of PHC RI microplan

Fig. 3.5. Timeline of activities in RI microplanning



This Gantt chart is indicative of average times needed for the major activities in developing the RI microplan. Variations are a reality and reasonable timelines specific to your area can be decided in discussion with district/colleagues.

Step 1

- **Block PHC/UHC meeting** – Sensitization and Review of existing microplans

Step 1 of the process for developing/updating the RI microplans involves 2 meetings:

1. A sensitisation meeting of all MOs, ANMs and other staff
2. ANM RI microplan review meeting

1. Sensitization meeting at PHC/Urban health center:

Call for a meeting at your PHC/ UHC to bring the focus on routine immunization and the process.

This meeting will:

- Sensitize all the staff on the process and their roles in RI microplanning
- Delegate activities to specific personnel with timelines
- Encourage discussion on issues
- Train ANMs on use of formats and conduction of head count / survey
- Finalize dates and schedule for the meeting with ANMs at PHC

In setups with multiple medical officers (Block/PHC/UHC): Conduct a meeting of all the MOs and ANMs to inform them of the plan for improving / updating the RI Microplan. Demarcate area of the PHC into sectors and allot each to a MO for supervision and follow-up. Sensitize them of the need for this activity and the process. Define roles; give specific responsibilities with reasonable timelines. Give specific responsibilities with focus on “what has to be done” “by whom” and “when”.

In setups with single Medical Officer (PHC/Additional PHC/UHC): Call for a meeting of all staff and inform them of the plan for improving / updating the RI Microplan. Sensitize them of the need, describe the contents of RI microplan forms and address any queries. Give specific responsibilities with focus on “what has to be done” “by whom” and “when”.

During this sensitization meeting:

For ANMs -

- Distribute at least 2 blank Form 1 sheets to all ANMs. Using the SOP for RI form 1 (page 39) discuss the format with them and ensure they are clear on how to use it.
- In Form 1 explain that a key element is to confirm areas under each subcentre and this form will become the master list. Ensure inclusion of:
    - All villages and their hamlets, tolas
    - Urban/peri-urban areas and their wards/sub wards/mohalla
    - Migratory and non migratory high risk settlements (slums, constructions sites, nomads, brick kilns)
- Record each HRA/Brick Kiln etc. in a separate row in the master list of areas
- Train ANMs on the proccess of conducting headcount survey (refer SOP for RI form 3).
- Instruct them to come prepared for the ANM RI review meeting with any RI microplan documentation available with them
- Finalize a schedule for meeting the ANMs.

2. ANM RI microplan review meeting - as per decided schedule:

This meeting should be conducted in small batches over 2 or 3 days to ensure that each ANM gets enough time to discuss and bring out issues in the planning process for RI.

The agenda points for discussion with each ANM must include -

a. Clear area demarcation for each sub center and ANM area
b. Review of Form 1 – master list
c. Proposing plan for missed areas, vacant sub centers including plans for areas without ANMs
d. Prepare maps (this will require a realistic timeline) also refer Unit 12
e. Assess adequacy of RI sessions
f. Proposing a communication plan
g. Any other issues related to RI microplanning

This step should not be completed in a SINGLE meeting – 2 to 3 days will be required, which need not be consecutive days. Plan these days taking into consideration all other activities and develop a schedule so ANMs can plan well.

Participants :

- Sector MO, Health supervisors, LHV, ANMs, key persons assisting MO/IC, Block program manager-National Health Mission, CDPO, ICDS supervisors etc.
- Immunization Field Monitor / WHO-Field monitor/SMNet partners where applicable

Preparations for the ANM RI microplan review :

The data manager of the PHC should generate the needed data for the PHC and each SC.

Data to be used: Review monitoring and coverage reports to identify issues in provision of immunization services with special emphasis on HRAs. Some suggestions are given below:

a) Vacant sub-centre areas
b) Areas with no sessions planned
c) Areas with no mobilizer assigned
d) Sessions with poor mobilization
e) Where planned sessions were not held
f) Areas with low coverage
g) Status of due-list updating, especially for migrants and new-borns
h) Inadequate supply of vaccines and logistics
i) Any serious AEFI
j) Staff position of ANM, AWW, ASHA, Supervisor etc.
k) Status of AVD/transportation (vehicle breakdown etc.)

Calculation of drop-out figures for each subcenter will help in identification of issues. However, this may not reflect specifically to each RI session site or village. Few suggested differences to be calculated per subcentre are between BCG and MCV1; Penta1 and Penta 3; MCV1 and MCV2; Penta 1 and OPV1 and Penta 3 and OPV3. **Refer Unit 7 for details.**

Table 3.4 below provides some of the data sources that can be used to help in planning the RI microplan . However, this is not an exhaustive list and if other data sources are available, they may also be used to compare information.

Table 3.4 - Sources of information for listing of areas and beneficiaries

Information / Data required	MOIC	ANM	ICDS Super-visor
Geographic	List & map of villages including hamlets / urban areas/wards	List & map of villages including hamlets /urban areas/wards (SC catchment area)	List & map of villages including hamlets / urban areas/ wards
Demographic	Total & beneficiary population (Census/ revenue records)	Total & beneficiary population (service records), migrants	0 -6 years registers, eligible couple register, etc.
Programmatic	Existing RI microplans, Polio microplans, monitoring feedback, Mission Indradhanush microplans (where applicable) List of HRAs	Existing sub centre RI microplans, Polio microplans, monitoring feedback, Mission Indradhanush microplans (where applicable) List of HRAs, VHND microplans	VHND microplans
Administrative	Staff vacancy to identify vacant SC	ASHA/ Mobilisers list to identify villages for focus	AWW/ helper list
Epidemiologic	VPD outbreaks	VPD data	
Social mapping	NGOs, Practitioners, Community centres, schools	Influencers, Possible session sites	

Suggested questions during ANM RI review meeting:

- Are all areas identified and included in the SC plan?
- Where are the unreached populations?
  - Areas with highest number of unimmunized children
  - Areas with mobile/migrant populations
- Where are the hard-to-reach populations?
  - Low coverage areas
  - Accessibility compromised areas

- Where is the population?
  - Are there areas/villages with large population?
  - Border/peri-urban areas?
- Are there problems with access to immunization services?
  - Catchment areas with Penta or other antigen <80%
- Where is utilization of services low?
  - Areas with high drop-outs

Outputs expected from this meeting:

- Master list of all areas for each sub centre in Form 1
- Plan for conducting house to house survey for each Sub centre
- Timeline for conducting the house to house survey / head counting

Roles and responsibilities:

Personnel	Activities to perform	Follow up by
MO/Ic	• Preparing for and conducting first meeting at PHC • Conduct SC RI review with few ANMs per day	DIO
Sector MO	• Actively participate in first meeting at PHC • Review progress of SC areas in allotted sector	Medical Officer in charge
ANM	Generate village list for each SC in coordination with frontline workers for the meeting	Sector MO / LHV / designated ANM
CDPO	Sharing of village list and AWW centre details	BPO
ICDS supervisors	Provide information on any areas / populations that may be overlooked	CDPO

DIO – District Immunization Officer; BDO – block development officer; LHV – lady health visitor

Each of the steps in the following pages includes detailed explanation of the RI microplanning formats to be used for each activity

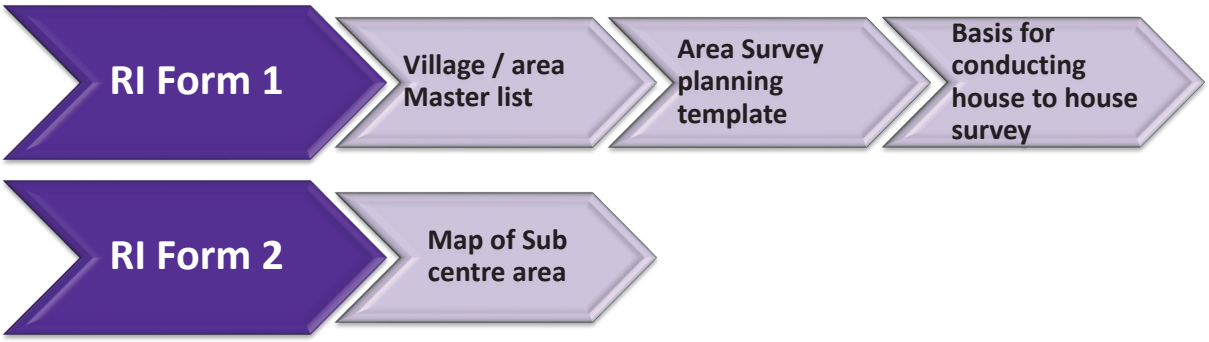
Overview and utility of the RI formats

A set of formats have been developed to collect and collate data to prepare RI microplans for an area . The table 3.5 below enlists these formats and the information they collect.

Table 3.5. RI microplanning formats and utility

Level of use	RI Form	Utility
PLANNING FORMS to be filled by ANM	1	• Master list of all the villages in sub centre area • Plan for conduction of survey
	2	Sub centre map
SURVEY FORMS Used In the Survey by ASHA / assessor area	3	Enlists all houses and occupants with focus on pregnant women and children in the age group of 0 to 2 years
	4	Enlists details of identified pregnant women
	5	Enlists details of infants / children identified
SUB CENTRE FORMS To be filled by ANM	6	RI Session beneficiary due list (to be made after SC microplan is approved by MO)
	7	RI session plan
	8	RI Session injection load and vaccine distribution plan
	9	Per session estimation of vaccines & logistics
	10	ANM work plan / roster
	11	Communication plan for SC
PHC FORMS	12	SC workload and Sessions plan
	13	PHC vaccine delivery plan including alternate vaccine delivery plan
	14	PHC vaccine and logistics per sub centre
	15	PHC – RI session supervision plan
	16	Emergency plan for vaccine storage
	17	Bio-medical waste management plan
	18	Communication plan for PHC/UHC

Overview of RI Forms 1 and 2



RI Microplan Form 1 – Sub-centre area survey planning form & Master List

SUB CENTRE AREA MASTER LIST and SURVEY PLANNING FORM

RI Form 1

Sub centre name:________________

ANM Name/Ph No.:____________________ **PHC Name:** ______________________ **District:**_________

s.no	Name of Villages / Hamlets / Tolas / HRA #	Total number of households in this area?	High Risk Area #	Name of ASHA designated for this area?	Name and contact number of person doing survey	Designation (encircle applicable)	Dates of Survey - From / To	FILL AFTER Survey - FOR ANM USE ONLY				
								Total Population	Total Pregnant Women	Number of new born (0 to 1 month) of age	Number of of Infants(1 month to 1 yr of age)	Number of children (1to 2 yr of age)
A	B	C	D	E	F	G	H	I				
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
			Y / N			ASHA/AWW/Other						
	TOTAL						TOTAL					

Signature of ANM______________________ Signature of Medical Officer:___________________

 # 1- Slums with migration; 2 - Nomads; 3 - Brick Kiln; 4 - Construction Site; 5 - Others (fisherman villages, riverine areas with shifting populations, etc.); 6 - Non migratory (settled population), hard to reach areas

SOPs for using RI Form 1

This format is to be used by the ANM of a sub centre area. Each ANM should list the areas in her sub centre including HRAs/nomadic sites in separate rows.

Column A - Serial numbers are to be allotted to each area. Numbers are not to be repeated and must be in serial for one sub-centre area. If the areas per sub-centre need to be entered on more than one sheet, the numbering will continue until the last area for that sub-centre.

Column B- Ensure all the Villages / Hamlets / Tolas / High Risk Areas (HRAs) details are entered. The classification of the HRAs is given as footer and the relevant number to be entered in brackets along with the name of HRA.

- For HRAs, (including brick kilns or nomadic/construction sites) ***each site must be entered into a separate row.*** Refer to existing polio microplans, census lists, maps, high risk area lists, and interactions with ASHA / AWW or Panchayat Raj Institution (PRI) members to ensure the inclusion of all areas in the sub centre area. This will form the **master list** for each sub centre. ***This is a critical activity***. Update this format as information is received or every quarter. (Refer Unit 12 for details on high risk areas)

Column C – enter the number of houses as per information available. If information is not available an approximate number can be entered. For areas such as nomadic sites and brick kilns household numbers are important or approximations must be entered.

Column D, if the entered area is an HRA then encircle “yes”.

Column E, Enter the name of the ASHA responsible for the area.

Column F, the name and contact number of the person who will conduct the survey should be entered.If the area does not have an ASHA or the position is vacant then, name of the person who will be delegated to conduct the area assessment should be entered.

Column G, The survey can be done by the local AWW / link worker / others in consultation with the Medical Officer (MO) **ONLY** after undergoing training. Enter the relevant designation.

Column H, The area survey is to be completed in seven to 10 days (See Fig 3.5). The dates for conducting this activity and the persons who will conduct the survey will be decided by the ANM in consultation with the MO. The **From** and **To** dates are to be entered here.

Columns I, The last shaded columns are for use **AFTER** the survey.

RI Form 2– Sub-centre map

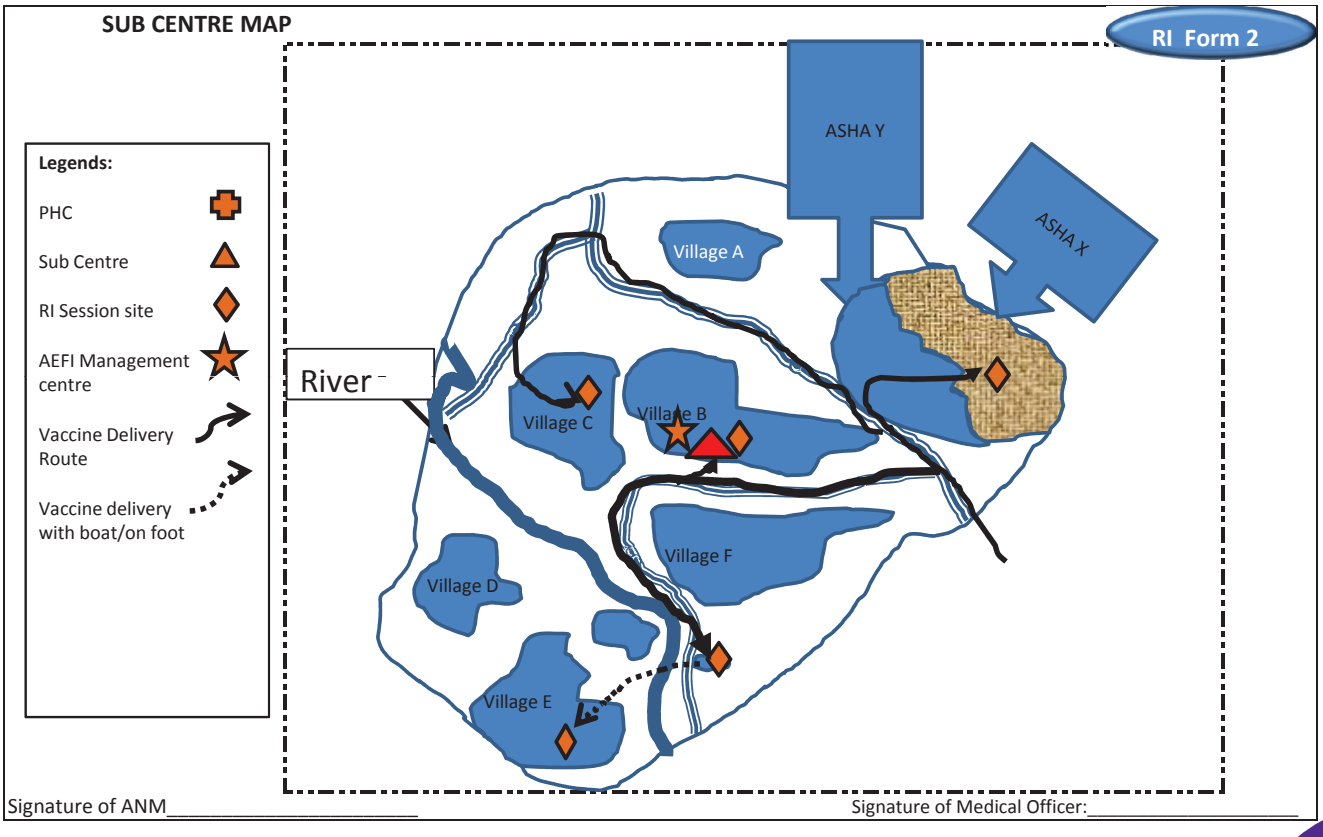
This form provides space for drawing a map of the SC area. A sample map is also given and health workers are encouraged to put forward simple drawings (see Figs 3.6, 3.7 and 3.8). The maps should be able to show at least the following:

- All the villages in the SC area, with names
- Shading of parts of a village to demonstrate the ASHA demarcation areas
- Location of the SC
- Location of all RI session sites
- Major roads
- Rivers streams.
- AEFI management centres

Each SC should have a map which helps to clearly demarcate the villages and areas to ensure that the frontline workers have clarity in operations, and avoid overlap or loss of services to the beneficiaries.

Encourage ANMs and ASHA to draw simple line diagrams of the areas; it is not necessary to have elaborate maps. (see next section)

Form 2 – Sub centre area map (Sample)



Making maps: updating maps made simple

Maps help to identify borders and areas of administration. They also help to identify areas that are in dispute or where workers have confusion.

In RI, simple maps are required (see Figs 3.6/3.7/3.8). The capacity to draw varies from person to person. Encourage your ANMs by showing printouts of the maps given as examples in this unit or demonstrate how simple line drawings can help them to be more sure and confident of their areas. Convey this message also to the respective ASHAs and AWWs of the area in subsequent meetings.

A good start for making maps begins with already existing maps. You should access the following sources:

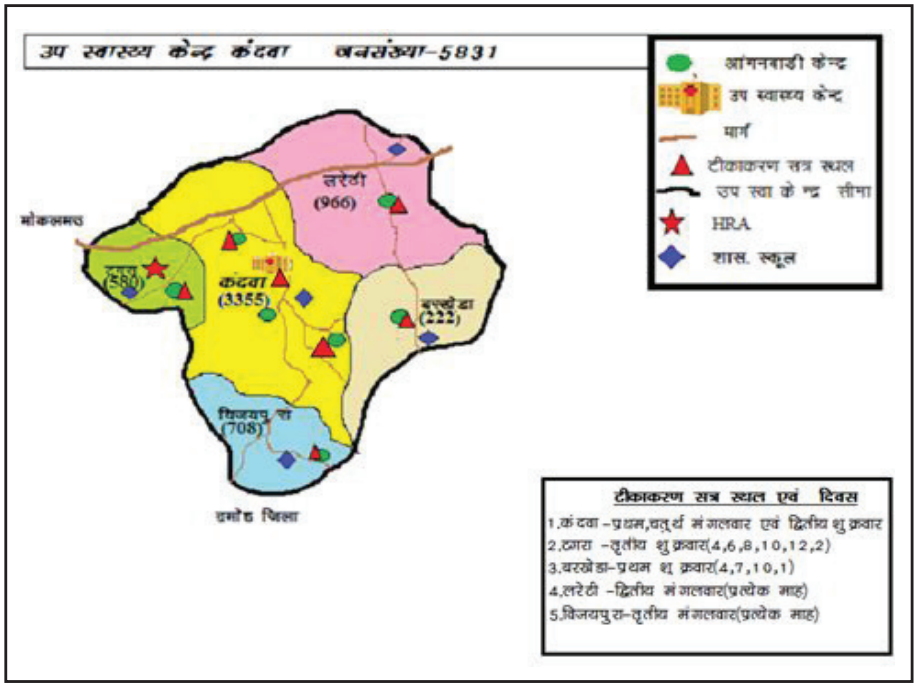
- Polio maps
- Maps from local administration, e.g. municipal corporation, land department, election section, local panchayat
- Local area maps from other sources.

(Refer Unit 12 for map utilization)

Ask the HWs to come to PHC with all the required data and guide them to prepare the SC/UHC microplans including maps.

Prepare a **map** of the block/PHC/Urban Planning Unit area, i.e. map showing the boundaries of SC/UHC, session sites, HRAs and demarcation of areas by each supervisor.

Fig. 3.6. Sample map showing area demarcation 1



Update the map of SC/urban health centre showing:

- the SC, villages, areas, hamlets and HRAs
- all Anganwadi centres, session sites and session days
- distance from the ILR point and the mode of transport
- landmarks such as panchayat bhavan, schools, roads,etc.

Fig. 3.7. Sample map showing area demarcation 2

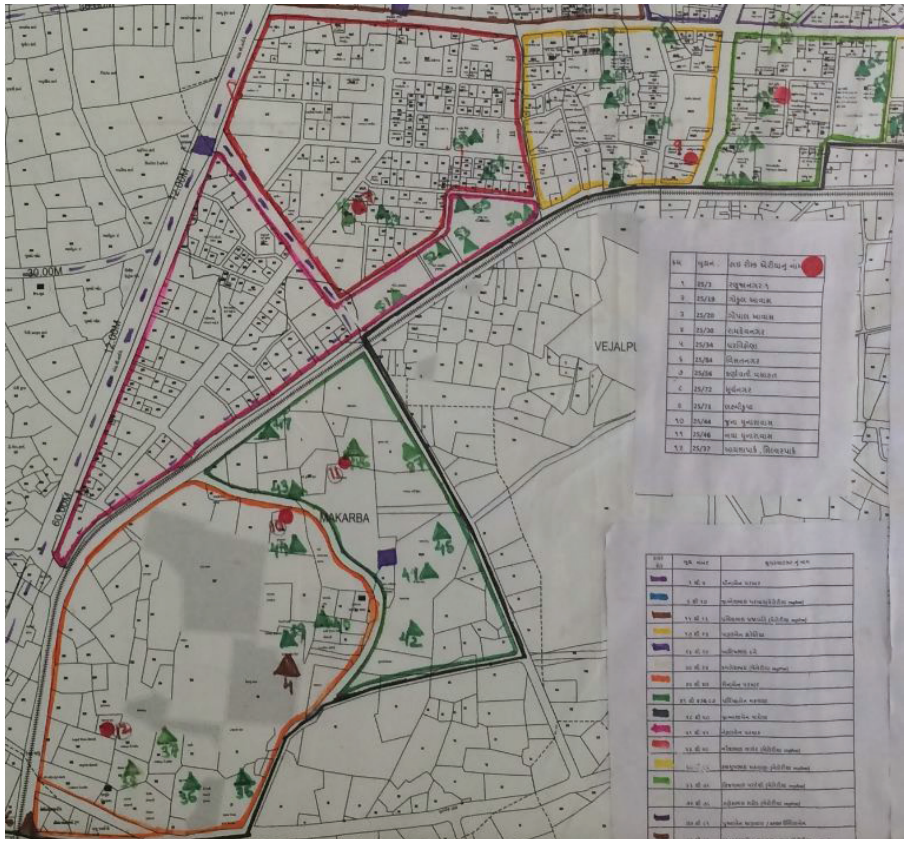
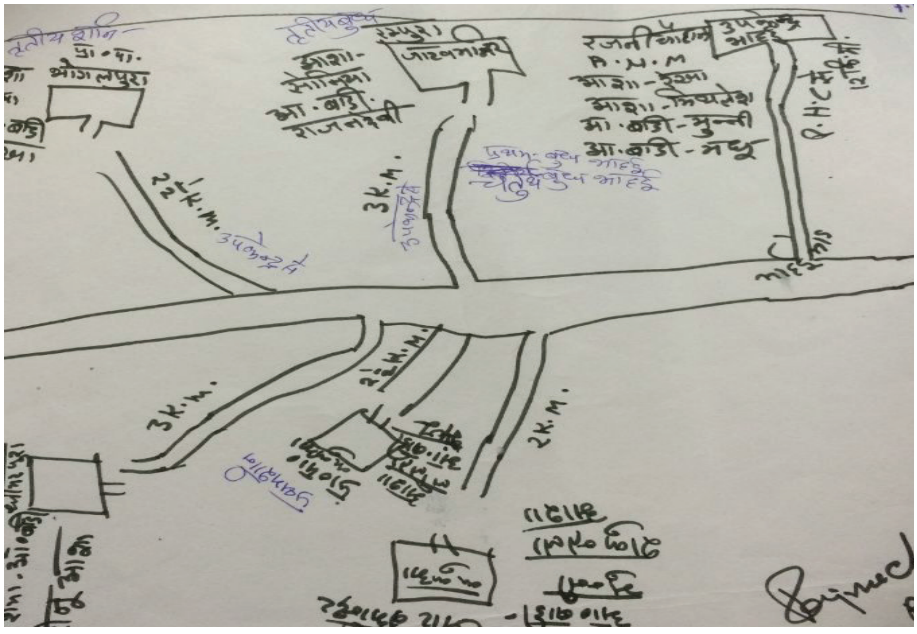


Fig. 3.8. A simple line diagram map

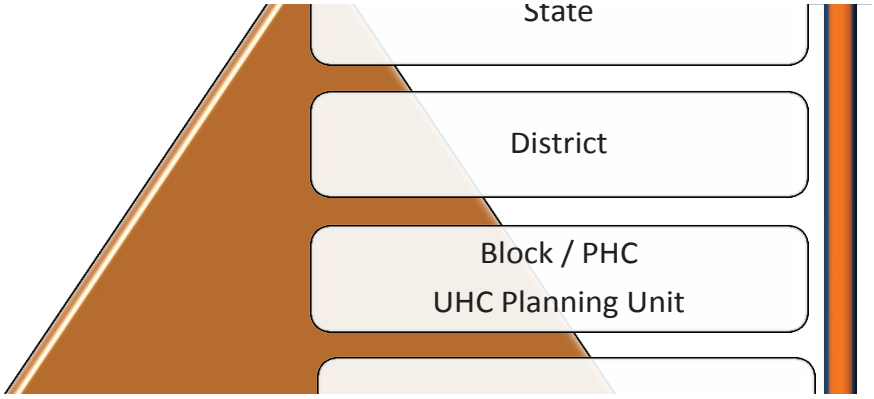


Step 2

- **Sub Centre level Planning** for head count survey and **training** of ASHA/AWW/Link worker/surveyor

The finalization of the head count survey plan and the training of the ASHAs/AWWs/Link workers/surveyors is the second step in the process for developing RI microplans. The role of the ANM is to guide the ASHAs and AWWs of the area in order to conduct the survey effectively and to use of their close ties with the community to identify all beneficiaries.

Fig. 3.9. Sub centre survey planning meeting– personnel and activities



Key components this activity should include:

- Review of area demarcation between ASHA, AWW & surveyors as per Form 1
- Sharing dates of survey and finalize with ASHAs/AWWs/link workers
- Creating working maps for each area
- Training ASHAs/AWWs/link workers to undertake head count & generate beneficiary list
- If required, plan to walk through areas to ensure clear area demarcation/HRA identification.

Medical Officer to decide on the venue for holding this meeting:

- At PHC for 2 to 3 Sub centres at a time– about 15 to 20 ASHA/AWW/Link workers in each batch, OR
- At Additional PHC, OR
- At the Sub centre.

Participants for this meeting : Sector Medical Officers, sub centre ANM, ICDS- lady supervisor, all ASHAs,AWWs,Link Workers, Mobilizers as well as ASHA facillitator of the villages in the sub centre.

Preparations

On meeting day

- Share the information and requirements for the meeting with respective ASHAs/ AWWs/link workers at **least a week in advance**. Encourage them to identify any new areas that may not have been included or any new nomadic or construction sites in their areas.
- Each ASHA and AWW should prepare a list of villages/areas as per the available information. This list should also include the HRAs and any other identified populations that require special services. Cross check and make corrections in the master list, if any.
- Discuss and plan logistics for the survey – adequate number of formats (Forms 3,4,5) ; chalk for house marking;

The MO/ANM need to share the status of RI in their area and explain the importance of the RI microplanning. Aspects that should be covered during the discussions are listed below.

Area demarcation between ASHA, AWW, link worker and mobilizer: Ask each ASHA/link worker to readout the list of villages/urban areas she visits/has been allocated. The AWWs of these areas can refer to the list they have prepared and add to or clarify the list of the ASHA. In some urban areas where AWW workers are not available, other key local persons can be approached for listing of areas.

Identify areas in each SC requiring a walk-through to verify demarcation and that all HRAs are included in the list of areas.

Using Form1 distributed during the PHC planing meeting, finalize the personnel who will conduct the headcounting and the approximate dates for completing the survey (if not already done). Allow for corrections of the master list at all times. Any information is important and will benefit the area.

Training of ASHA/AWW to undertake head count and generate due beneficiary list: Distribute copies of Forms 3, 4 and 5 to each ASHA/AWW. Explain the process (use SOPs of each form) for conducting the house to house survey of the areas, the information they will collect and the process for filling up these forms.

Develop a practical timeline considering that a maximum of 25 to 30 houses are to be covered in one day. This will ensure quality and allow the workers to collect detailed information on each family. **Rushing this process will lead to a compromise in quality.**

Creating working maps for each area: Working maps are simple maps (Figs 3.6/3.7/3.8) which need not be to scale, but provide an overview of the areas with clear lines of demarcations if there are more than one HW. These maps should be developed before going out into the area. Finer details may be added to this map during or in the next part of the process. Refer section on "Making maps" in this unit and also Unit 12.

Walk through of areas to ensure clear area demarcation/HRA identification: Once the training is completed the MO/ANM along with the ICDS LS should visit some areas. Priority should be given to those areas where confusion of demarcation exists and HRA areas. A walk through will bring an agreement on the lines of demarcation and will verify all HRAs are included in the list of areas. If there are a large number of areas, or the identified areas are accessibility compromised, the field visit can be covered as per a practical timeline over a few days.

Before closing the meeting, confirm the dates for the area survey by each person as per Form 1 and clarifi any doubts of the participants. Coordinate with ICDS supervisors to ensure monitoring and oversight. Working maps generated can be strengthened with additional information during the survey. Any changes should be intimated to the concerned ANM and ICDS supervisors.

Outputs expected

- Confirmed plan for area survey with timelines and names mentioned in Form 1.
- Refined master list of all areas in the SC
- Simple area maps for each ASHA area

Roles and responsibilities

Personnel	Activities to be performed	Supervisor
MO/Sector MO	• Will support the SC personnel to finalize plan for area survey • Supervise the survey with field visits	MOIC
ANM	• Area demarcation for ASHAs/AWWs • Develop a reasonable timeline for survey • Will support the ASHA/AWW for survey • Supervise the survey with field visits	Sector MO/LHV/ designated ANM
ASHA	• Contribute to finalizing the master list • Conduct the house-to-house survey	SC ANM/ASHA facilitator
AWW	• Conduct/assist in the house to house survey • Identify beneficiaries/HRAs/missed areas/ dropouts/left-outs	SC ANM/LS

Step 3 • **Conducting** head count survey at village /ward

The head count survey or house-to-house survey is the third step of the RI microplanning process. The survey will ensure enrolment of all beneficiaries in an area. It is to be conducted by the ASHA/AWW/Link worker/surveyor (after training) as specified in Form 1. No person will conduct this activity without having undergone the training as mentioned in Step 2. Each ANM will have a list of the SC areas and the dates for conducting the visits. This is to be shared with the LHV/Ladies Supervisor (LS) of ICDS to enable field visits and monitoring.

Key activities to be conducted:

- ASHA/AWW/LW/surveyor will conduct the survey as per the plan in Form 1. Support may be sought from local residents while conducting the survey. This survey is NOT to be done on RI days.
- During the survey
  - A maximum of 25 to 30 houses should be covered per day.
  - Information of ALL households to be entered in Form 3.
  - On identifying a pregnant woman in a household, enter her information into Form 4
  - On identifying infants and children up to 2 years of age, enter information in Form 5.
  - Process to be completed in 7 to 10 days per area.
- Monitoring of the process by ANM/LHV/LS/Sector Medical Officer/Medical Officer In-charge/DIO.
- Involve other departments (e.g. education, PRI, etc.) and block/district administration in supervision of this activity.

The minimum activities to be conducted are as follows:

Participants

Designated ANM, ASHA, AWW, LW or identified person for conducting the survey, Sector MO, ASHA supervisor, LS, others.

Preparations

The ANM should review the available lists and maps from Step 2 before beginning Step 3. During the period of survey, ANM and LS (ICDS) will make coordinated visits to ensure that the ASHAs/AWWs/LW/surveyors conduct the activity as per the training given.

ANM/ASHA facilitator/LS should verify at least 5 households. Adequate numbers of formats need to be made available for this activity to make maximum use of the resources in the field. All queries need to be addressed at the earliest. Upon completion of the activity and after verification the ANM should sign the Forms 3, 4 and 5.

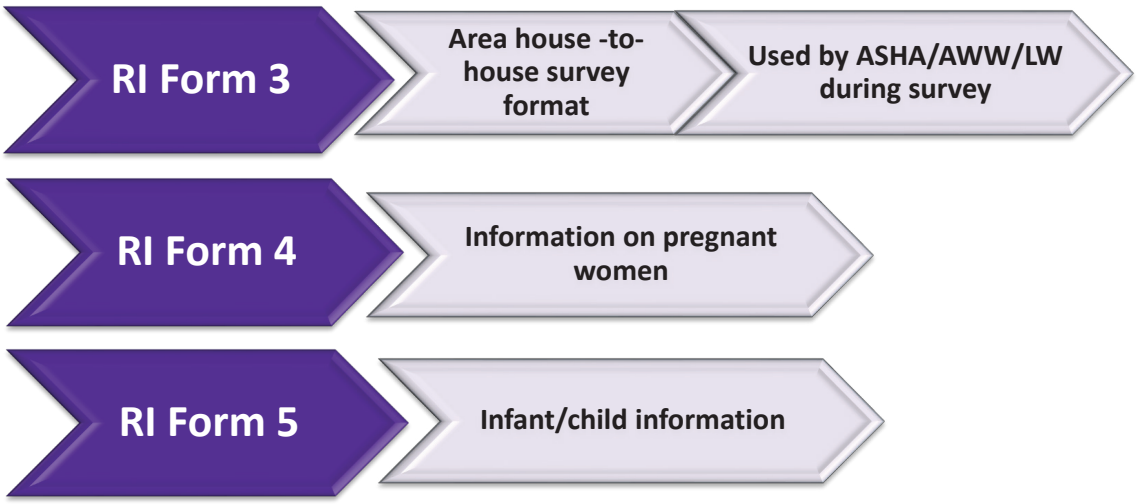
Use of local mobilizers

It is essential that the ANM interacts with the mobilizers and encourages other influencers in the village to participate in the survey activity.

Supervision

Sector MOs will visit the areas and provide oversight during this important phase of the microplanning exercise. An overview of Forms 3, 4 and 5 is given in Fig. 3.10.

Fig. 3.10. Overview of RI Forms 3 to 5



Outputs expected

- ASHA/AWW/LW/surveyor conducting the survey as per training
- Completion of house-to-house survey
- Forms 3 ,4 and 5 identifying all beneficiaries for each area.

Roles and responsibilities

Personnel	Activities to be performed	Supervisor
Sector MO	Supervise with field visits	MOIC
ANM	Supervise with field visits	Sector MO/LHV/designated ANM
ASHA	Conduct survey and fill Forms 3,4,5	SC ANM/ASHA facilitator
AWW	Conduct survey and fill Forms 3,4 and 5/ assist in survey	SC ANM/LS

RI Microplan Form 3 – Area survey/house to house survey form

RI Form 3

House to House Survey form

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

Sub-Centre name:________ Name of ANM: ____________

Area Name and No as per Form 1: ________

Date of Visit : dd/mm/yy

First house visited today - House No. :_________
Name: Address with landmark:

Last house visited today - House No. :________
Name: Address with landmark:

Family Details				Pregnant Woman	Children 0 to 2 years - (if YES , go to form 5)		
House number (as per chullah)	Name of head of family	Fathers name	How many family members are living in this house? (Include All adults & children including new borns)	Is there any woman pregnant in the family ? (If YES, go to form 4)	Is there any Newborn/child aged less than 1 month in the family (if YES , go to form 5)	Is there any child aged between 1 month and 1 year in the family (if YES , go to form 5)	Is there any child aged between 1 to 2 Years in the family (if YES , go to form 5)
A	B	C	D	E	F	G	H
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
				Yes / No	Yes / No	Yes / No	Yes / No
Total		TOTAL		Total Yes	Total Yes	Total Yes	Total Yes

Signature of ASHA/assessor:______________________ Verified by ASHA Facilitator (Signature):____________________ Verified by ANM (Signature):________________

SHEET NUMBER :________

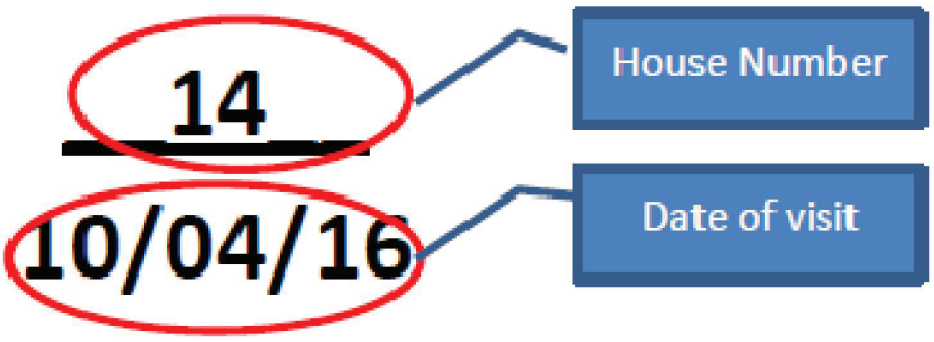
SOPs for using RI Form 3

- Form 3 is to be used when conducting the house to house survey.
- Each sheet must have the area name and number as given in Form 1. The ANM must instruct the surveyor to enter this.
- This assessment is not to be done on RI days.
- A household is defined based on "Kitchen" or "Chullah"
- Each sheet has information for 15 households. Multiple sheets for each area will be required and must be made available.
- A maximum of 25 to 30 houses should be covered per day. Calculations for the number of days will depend on the timeline as per DTF-I decisions.

Details of the first house visited and the last house on each sheet must be entered in the space provided. When multiple sheets are used in an area, each sheet must be numbered in the space provided at the bottom right of the form. The working map of the area prepared will help in identifying the roads and location of houses. Changes to this map can be made during the survey.

All houses in the area must be visited and information entered into the form. Each household is to be identified by a number (Column A). **This is the household identification number.** The numbering of households is to be continuous until the area is completed. The assessment of the area may take more than one day but the **numbering of the houses will be in serial order for the entire area.** Restart of numbering will be done when a new area is being assessed by the same person. House marking should be done with chalk/geru indicating the serial No of the household and date of survey, as shown in Fig. 3.11.

Fig. 3.11. House marking during house-to-house survey for RI



Interview each household and gather information on the head of household (Column B) and the total number of members in each household (Column C). This must include all newborn children.

Next, enquire if there is any currently pregnant woman in this household. This does not depend on if she is a resident / visitor to the area. Include all pregnant women as each is a beneficiary. If yes, then encircle yes (Column D) and collect information on the pregnant woman and enter in Form 4.

Similarly for Columns F, G and H enquire if there is:

- A newborn child
- A child up to 1 month of age
- A child between 1 month and 1 year of age
- A child between 1 and 2 years of age.

If a child is identified in any of these columns, encircle "Yes" and enter information on the newborn/infant/child in Form 5.

VILLAGE/ AREA - Pregnant Women Survey Listing

RI Form 4

Name of ASHA/AWW/ assessor: _____ Area Name and No as IN Form 3: _____

Name of ANM:_____

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

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

SOPs for using RI Form 4

Form 4 has to be filled when a pregnant woman is identified in Form 3 Column E.

The number in Column A must be the same as that used to identify the household in Form 3.

This number is a unique number that will link the pregnant woman to the house details.

Columns B, C, D and E are for information which identifies the pregnant woman.

Column F. Enquire from the woman if she has been issued a mother and child protection (MCP) card and accordingly encircle Yes or No. If she does not have a card, then information should be shared with the ANM of the area to ensure that a card is issued to her during the next visit.

Column G. Determine the expected date of delivery (EDD) of the child. This can be sourced from the RI/MCP card if available or from the mother herself. If she is unaware, then determine the EDD as best as possible by assessing her date of last menstrual period (LMP). **(Surveyor can consult ANM who can refer to the EDD ready reckoner from RCH register/ training manual).**

The administration of TT vaccine to PW as per the UIP schedule prevents maternal and neonatal tetanus; details of the same are to be entered in the three H Columns.

Antenatal check-ups help to identify a high-risk pregnancy and reduce chances of any complications. Details of these checks are to be entered in the four (I Columns).

Column J. this is for the ANM to enter if the woman is due for any ANC or TT vaccination. These two columns make it easier for the ANM to extract the information and develop the beneficiary due list for each RI session.

The dates of administration of TT injections and ANC check-ups should ideally be obtained from the RI/MCP card.

RI Form 5– list and details of infants / children identified

SOPs for using RI Form 5

This form collates all the information of infants/children identified during the house to house survey.

When filled correctly, this form provides information needed to develop the beneficiary list of infants/children of the area. **Accurate information on the number of children and the vaccines that they are due for will help to identify which vaccines a child is to receive, and when.**

Name of ASHA/AWW/ assessor: _____ Area Name and No as per Form 1: _____ Infants

House No as in Form 2	Name of the child	Age in yrs and months	Sex M/ F	Name of the father and mobile number	Is MCP card available: Yes / No	Vaccines at birth			Vaccines at 6 weeks				
						Hepatitis B birth dose (Witin 24 hours of birth)	OPV-Zero dose (within 15 days of birth)	BCG (At birth or upto 1 year of age and as early as possible)	OPV-1	Penta-1	RVV-1	fIPV-1	PCV
A	B	C	D	E	F	G			H				
						Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/
					Yes /No								
					Yes /No								
					Yes /No								
					Yes /No								
					Yes /No								
					Yes /No								
					Yes /No								
					Yes /No								

Signature of ASHA/AWW/ Assessor_____

Column A. The number in Column A must be the same as that used to identify the household in Form 3. **If there is more than one child in a house, the same number will have to be entered for each of these children.**

Columns B, C, D and E. These columns are used to collect identification information of each child. Attempt to collect the latest mobile number from the parent/household.

Column F - Enquire if the infant/child has been issued an RI/MCP card. If not, information should be shared with the ANM of the area to ensure that a card is issued at the earliest.

Column G. This records detail of vaccines administered at birth. Dates are to be entered of when BCG, OPV birth dose and Hepatitis B (within 24 h) were administered.

Column H. Dates of administration of Penta 1, Rotavirus 1 (where applicable), PCV 1 (where applicable), fIPV 1 and OPV 1

Column I. Dates of administration of Penta 2, Rotavirus 2 (where applicable) and OPV 2

Column J. Dates of administration of Penta 3, Rotavirus 3 (where applicable), PCV 2 (where applicable), fIPV 2, and OPV3

Column K. Enter the dates of administration of vaccines due between the age of 9 months and 1 year – MR first dose, Vitamin A, PCV Booster (where applicable) and JE (where applicable) vaccines

RI Form 5

ants / children survey listing Name of ANM: _____

	Vaccines at 10 weeks			Vaccines at 14 weeks					Vaccines at 9 to 12 months					Booster and 2nd doses of Vaccines at 16 to 24 months of age					
PCV-1	OPV-2	Penta -2	RVV-2	OPV-3	Penta -3	RVV-3	fIPV-2	PCV-2	Measles / Rubella 1st dose	JE 1st dose	PCV Booster	Vitamin A 1st dose	For Fully Immunized (FI) child - has incentive been given to ASHA	OPV Booster	DPT Booster	Vitamin A	Measles / Rubella 2nd dose	JE 2nd dose	For Completely Immunized (CI) child - has incentive been given to ASHA
	I			J					K				L	M					N
Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	Date/Y/N	
													Yes /No						Yes /No
													Yes /No						Yes /No
													Yes /No						Yes /No
													Yes /No						Yes /No
													Yes /No						Yes /No
													Yes /No						Yes /No
													Yes /No						Yes /No
													Yes /No						Yes /No
																			TOTAL

Verified by ASHA/AWW Facilitator (Signature):_____

Column L. Record whether the ASHA has received the incentive for the child who is fully immunized – encircle "Yes" or "No". A child is to be considered as **fully immunized** if s/he has received all the due vaccines up to 1 year of age.

Column M. Dates of administration of vaccines due for a child between the ages of 1 and 2 years are to be entered in column M. This includes MR second dose, OPV booster dose and JE vaccine (where applicable).

Column N. Has ASHA has received the incentive for the child who is completely immunized– encircle "Yes" or "No". A child is to be considered as **completely immunized** if s/he has received all the due vaccines up to 2 years of age.

Step 4 • **Review** of all survey forms & **consolidation** of Sub Centre microplans

Each ASHA/AWW/LW/surveyor submits Forms 3, 4 and 5 to the ANM after completing the area survey. Step 4 is to review and collate this information.

ANM should plan for this meeting and inform all participants of the venue, date and time at least 2–3 days in advance so that they attend the meeting with completed survey forms.

Facilitator: ANM/Sector MO
Participants: ASHA/AWW/surveyor with ASHA facilitator, LHV/LS to attend if possible
Key activities to be conducted:

- Area demarcation to be finalized on map
- Review and refine RI plans as per actual head counts & identification of any missed (migratory/ settled) pocket in sub centre area
- Ensure functional tagging – areas tagged to existing RI sites should be practical
- Consolidation of Routine Immunization Microplan at sub centre – Form 6,7,8 & 9
- Develop mobilization plans
- Update the map of sub-centre/urban health centre showing:
    - All HRAs, villages with hamlets, urban areas with wards, sub wards & mohallas
    - All session sites and session days including Anganwadi centres
    - Distance from the ILR point and the mode of transport.
    - Landmarks as Panchayat Bhavan, school, roads etc.
    - Demarcate ASHA/mobilizer wise areas for social mobilization on map

Preparations

The Sector MO must review the plan of the ANM; timely oversight will ensure the development of effective RI microplans. MO should guide the ANM and extend support with visits and reviews.

During the meeting

ANM will review the information collected during the house to house survey in Forms 3, 4 and 5 with the ASHA/AWW/link workers/surveyor. A simple map of the SC can then be made from the information and experiences of the workers who have completed the survey. This map need not be to scale, but should include area demarcation for ASHA/AWW/mobilizers and other information as mentioned above.

As the actual head counts and areas are now available, review and refine the RI session plans to address the following issues:

- Are the number of sessions presently sufficient?
- Are all the areas covered?
- Are the migrants/HRAs identified? If so, are RI sessions being conducted for these mobile populations?

Session due list (Form6) –With the information gathered in Form 4 and Form 5, it is now possible to correctly quantify the number of beneficiaries.

The role of the ANM is crucial in this meeting. The focus must be on three points – beneficiary list, area finalization and mapping. The ANM Should remember that these tasks require investment in time and this meeting may take more than one day. RI Form 6 is the session due list and is best to be filled in Step 5 after finalization of the SC micorplans. A draft may be prepared but in discussion with MO Planning by the Sectoral MO should take this into consideration to enable him to attend if possible.

Outputs expected

- Number of new areas identified
- Number of beneficiaries
- Consensus on listing of areas and HRA
- Consensus on demarcation of areas
- Formats collected after cross check and attestation
- Availability of maps.

List of documents after conduct of the SC meeting:

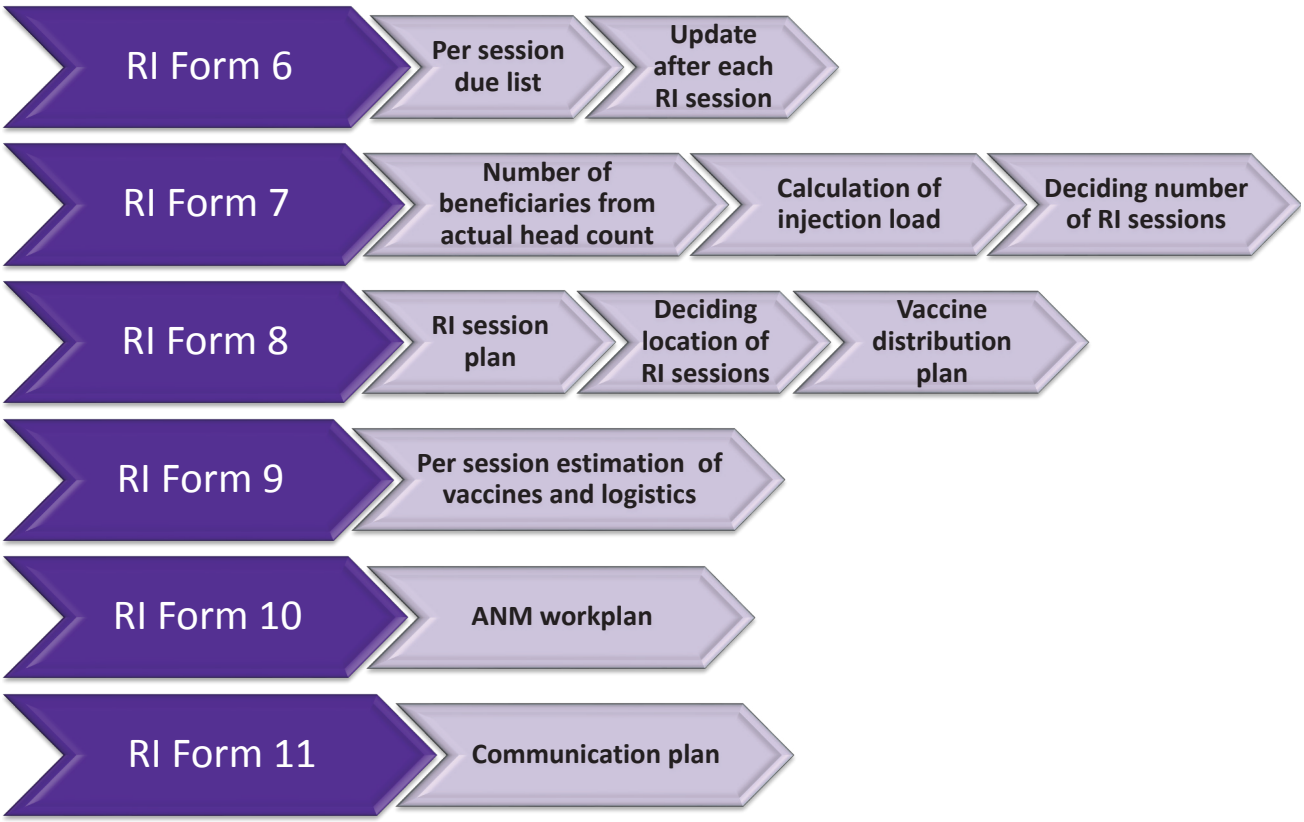
1. Completed RI Form 3 for each area
2. Completed RI Forms 4 and 5 –Beneficiary list – as per ASHA/areas identified
3. RI Form 7– proposed sessions planning for SC
4. Map of the SC – Form 2 showing demarcation of areas for ANMs (if applicable), ASHAs and AWWs

An overview of RI Forms 6 to 11 used in the SC RI microplan is given in Fig. 3.12.

Roles and responsibilities

Personnel	Activities to be performed	Supervisor
Sector MO	Monitor surveys, review forms in the field Oversee the meeting at SC where possible	MOIC , DIO
ANM	Conduct the meeting at SC Finalize area listing and draft of plan for conducting RI sessions in the areas	MOIC ,Sector MO
ASHA	Contribute to final forms	SC ANM/ASHA facilitator
AWW	Contribute to final forms	SC ANM/LS

Fig. 3.12. Overview of Sub Centre RI Microplan – Forms 6 to 11



RI SESSION DUE LIST

PHC: _____

RI Form 6

Name of Sub-Centre : _____

Name Session Site : _____ Block : _____

Name & No of ANM :_____ Name & No of ASHA : _____ Name & No of AWW : _____

Details of Pregnant Women / Children due for vaccination for RI session								After the RI session			
Sl. No.	MCTS Registration No.	Name of Child / Pregnant Woman	Date Of Birth / Expected date of Delivery	Age	Sex M / F	Name of Father/Husband	Vaccines due in this session	Did the pregnant woman / child arrive today? (Yes/No)	Vaccines which were administered to pregnant woman / child (If not given mention reason)	*Incentive money Rs. 100 will be payable to ASHA under Part C.5.A. for Full Immunization	**Incentive money Rs. 50 will be payable to ASHA under Part C.5.B. for Complete Immunization
A	B	C	D	E	F	G	H	I	J	K	L
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
									Total amount received		

Number of beneficiaries who did not attend	Out of Village	Sick	Refused	Vaccinated outside	Other
Have these beneficiaries been included in the next session?	Y/N	Y/N	Y/N	Y/N	Y/N

Total Number of Pregnant women as per the due list	
Total women vaccinated	
Total number of children as per due list	
Total children vaccinated	

Signature of ANM *Signature of ASHA* *Signature of AWW*

This form is to be filled after finalization of SC microplans with medical officer

SOPs for using RI Form 6

This form is the session due list. **It identifies the number of beneficiaries per session and the vaccines for which they are eligible during the RI session.** This is also the record of payment of ASHA incentives.

This format is to be prepared by the ANM with support of the ASHA/AWW/LW after the proposed microplan is approved by the medical officer.

This session due list will help the ASHA in mobilizing beneficiaries to the session/s. Use a calendar and share the dates of upcoming sessions with ASHA/AWW/LW in advance to allow for mobilization.

Form 6 – Note

- This is a session due list and incentive recording sheet
- To be filled after finalization of microplan with medical officer
- ANM to compile the session beneficiary due list from the information
- Where possible, the MCTS number of PW is to be entered

Column A: The serial number for each beneficiary is to be entered here.

Column B: MCTS registration number is to be entered where available. ANM can provide this information from her RCH register. This unique number will help track the beneficiaries for complete immunization.

Column C: Name of the child/pregnant woman identified for services during this session is entered here.

Column D: For children enter the date of birth and for PW the expected date of delivery, if known.

Column E: Enter the age of the child in months or age of pregnant woman in years and months.

Column F: Enter the sex of the child.

Column G: Enter the name of the father or husband for easy identification at the village level.

Column H: Enlist all the vaccines that the beneficiary is due for in the upcoming session.

The following columns are to be filled at the end of the RI session:

Column I: After the completion of the RI session, cross check that all beneficiaries had arrived, answer as Yes or No

Column J: Enter all the vaccines were received by the beneficiary during this session. If not received,mention reasons.

Columns K and L: These are to be filled as and when ASHA receives her payments.

Presentation of this form

This format is not to be used singly. Each sheet to be in triplicate (different colours) and numbered. ANMs should use carbon sheets while filling the form. It is recommended that a booklet containing enough sheets for one year be printed to enable continuous use of the information and developing of a realistic RI session due list.

Maintaining the session due list after every RI session

- Who are the children who were due for vaccination today but did not turn up?
- Why did they not turn up?
- Who are the children we did not list for today's session?

It is essential that the left-out and drop-out children be identified. These children are at maximum risk as their immunization cover will not be complete and makes them susceptible to VPDs. Incomplete immunization contributes to child deaths under the age of 2 years.

Therefore, after each session the ANM, ASHA and AWW must review the children who have not come to the session. The reasons for not coming, once identified, must be addressed by the team. Seek support from local influencers/key persons to identify any children or beneficiaries before leaving the session site.

Enlist all children **who had not come** in for the session conducted, irrespective of the reason. After these names, enter the names of children **who will be due** for any vaccine in the next session. Share this list with the ASHA/AWW/LW so as to give them sufficient time to visit these houses and use all possible methods to convince the parents or ensure that the children are vaccinated at the fixed site at the PHC or in the next session.

As per the SC RI microplan, the ANM should remind the ASHA/AWW/LW on the next session date before leaving the session site.

Subcenter / UHC - RI Sessions plan

RI Form 7

District: _____ Block/PHC/Urban Planning Unit: _____ **SC/UHC: _____**

Name of IO / ICC: _____ Mobile no.: _____ Name of Medical Officer I/C: _____ Mobile no.: _____

Name of ANM: _____ Mobile no.: _____ Name & Designation of Supervisor: _____ Mobile no.: _____

S.No	Name of Villages / Hamlets / Tolas / HRA #	Total Population of Area (Totals of form 3 Column D)	Beneficiary Targets				Monthly Injection Load	Number of Sessions	Name and location of the Session site / sites	Name of the mobilizer	Type of area / terrain - plain / hilly / riverine	Type of Session - Fixed / outreach/ mobile / tagged
			Annual Target (PW = Actual Head count X2 , Infants =Actual Head count)		Monthly Target							
			PW	Infants	PW	Infants						
A	B	C	D	E	F	G	H	I	J	K	L	M
					D/12	E/12						

 # 1- Slums with migration; 2 - Nomads; 3 - Brick Kiln; 4 - Construction Site; 5 - Others (fisherman villages, riverine areas with shifting populations, etc.); 6 - Non migratory (settled population), hard to reach areas

Less than 25 injections: One session every alternate month**; 26-50 injections:** one session per month**; more than 50 injections:** two sessions per month as per need**; For hard to reach areas or less than 1000 population, where not tagged,** plan for sessions every quarter for a minimum of 4 sessions a year **; for a busy PHC/CHC/RH: plan daily sessions.**

SOPs for using RI Form 7

Enter the serial number and name of the villages in **Columns A and B**, keeping the same order as in Form 1. **New areas /identified missed areas should be entered towards the end with clear marking that this is a new area, using an asterisk (*).**

Using Form 3 Column D, the individual areas actual population (from the survey) should be entered into **Column C.**

The information for Column D is of the annual target of PW in each area.

Annual target of PW = Number of PW identified in the area survey X 2

The information for **Column E**

Annual target of infants = actual number of infants identified during the area assessment.

Calculating annual and monthly target population

Beneficiaries in the UIP are the PW and the children of an area who are eligible for any vaccinations. The cardinal numbers of these beneficiaries is obtained by conducting the area and house to house survey. Once the survey is completed, these figures will be available from Form 3.

However, for calculation of the yearly and monthly number of beneficiaries it is necessary to do the following:

- **For pregnant women:**

  The survey will give the number of PW identified in an area at the time of conducting the survey.

  The annual target of PW = actual number of PW as per head count X2

- **For children:**

  The house to house survey also identifies child beneficiaries. For the calculation of the annual target the actual number identified is considered.

  The annual target of children = actual number of children as per headcount

For columns F and G

Monthly target of PW = Annual target divided by 12

Monthly target of children = Annual target divided by 12

In column H

Enter the monthly **injection load for each area.**

Calculating injection load (only for determining the number of sessions)

This calculation is to be used only as a planning tool and ***not for estimation of vaccines or logistics.***

Firstly, determine the total number of injections needed per beneficiary.

This gives a multiplying factor of **15 injections.**

- BCG – 1 injection
- DPT – 2 booster injection
- HiB containing Pentavalent – 3 injections
- fIPV – 2 injections
- MR Vaccine – 2 injections
- PCV – 3 injections (where applicable)
- TT– 2 injections (for pregnant women)

For districts where JE is included in the schedule **add 2** to the above number, giving the multiplying factor of **17 injections.**

Injection load = Monthly target of children from **Column G** multiplied by the above factor

Column I

Based on the monthly injection load the number of RI sessions to be conducted for each village/area is to be entered as per the guideline below.

Frequency of RI sessions depending on injection load –

- 1 to 25 injections – 1 session every alternate month
- 26 to 50 injections – 1 session every month
- 51 to 100 injections - 2 sessions every month

For hard to reach areas or less than 1000 population, where not tagged, plan for sessions every quarter for a minimum of 4 sessions a year

Column J describes the location of the vaccination site. It is important that the exact location be entered, preferably with a landmark. This helps to collate the information and makes it easier to develop the overall plan for RI sessions under the SC area.

Mobilizers play an important role in mobilizing beneficiaries to the RI session site. The name of the mobilizer is to be entered into **Column K.**

Column L. Describes the type of terrain as this is a factor that contributes to determining

the number of sessions in the area and the method of vaccine delivery. The areas may be as follows:

- Plain – flat and accessible with no compromise in accessibility
- Hilly – hilly area
- Riverine – area divided by a river or rivulets making access difficult
- Inaccessible – hard to reach due to absence of roads or is approachable only by foot.

Column M. Describes the type of session. Sessions can be:

- **Fixed.** These sessions are held where vaccine storage is possible because of availability of ILR and deep freezer (DF), i.e. the sessions conducted at PHC/CHC
- **Outreach.** All sessions conducted where vaccine has to be taken by vaccine carrier
- **Mobile.** Sessions conducted using a vehicle which moves from site to site along with the immunization team and vaccine
- **Tagged.** Site/area which does not have a session but is linked to the nearest session site.

Ensuring “Same day, Same site, Same time”policy will help to increase community acceptance and in turn the utilization of services provided.

Sub Centre/ UHC: Per Session Injection load and vaccine distribution plan

RI Form 8

District: _____ Block/PHC/Urban Planning Unit: _____ SC/UHC: _____

Name of Medical Officer I/C: _____ Mobile no.: _____ Name of IO / ICC: _____ Mobile no.: _____

Name of ANM: _____ Mobile no.: _____ Name of Supervisor: _____ Designation:_____ Mobile no.: _____

S.No	Name and location of Session Site (Exact location) **If >1 session sites in big villages mention each separately**	Name/s of village/sub village area /hamlet/ urban ward/ mohalla/ tola covered by the site with its sl no. from Format 1 **(all areas in one cell separated by comma)**	**Frequency of Sessions** (Once a quarter / once in 2 months / number)	**Target for the session** (add if multiple areas / tolas are clubbed or divide in case of big village)		**Per Session doses required for each vaccine & vitamin A**											**Injection Load for the session** (TT+BCG+DPT +Hep B +Penta +MR+JE+PCV)	THESE COLUMNS TO BE FILLED AFTER APPROVAL OF PROPOSED PLAN BY MEDICAL OFFICER					
				PW	**Infants**	TT	BCG	DPT	OPV	Penta	RVV	fIPV	MR	JE	Vit A	PCV		**Month 1** ____	**Month 2** ____	**Month 3** ____	**Vaccine Distribution**		
																					Mode of Transport	**Name of person responsible**	**Contact number**
						EX2	FX1	FX2	FX5	FX3	FX3	FX2	FX2	FX2	FX9	FX3		Day (Wed 1-5 or Sat 1-5)					
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V		
1																							
2																							
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15																							

 # 1- Slums with migration; 2 - Nomads; 3 - Brick Kiln; 4 - Construction Site; 5 - Others (fisherman villages, riverine areas with shifting populations, etc.); 6 - Non migratory (settled population), hard to reach areas

The form contains detailed information on each RI session site in the SC. It also contains details on frequency of sessions, the villages/areas covered or tagged with each site, the injection loads per antigen and the vaccine distribution plan for each session.

SOPs for using RI Form 8

In **Column A,** enter the serial number.

In **Column B,** this is the name of the RI session site.

Enter each RI session site in a separate row. It is important that the exact site location be entered. **This will give the exact planning of sessions for the SC on a single page**. If the site is located in an Anganwadi centre, also include the centre number and location. If the site is located in private premises, the house owner's name should also be entered. Include a landmark where possible.

Column C. This contains the names of areas to which a RI session site provides services. Enter the names of the village/s or areas as per Form 1. For multiple areas, write the names separated by commas into this column.

E.g – Village XYZ

The frequency of sessions at this RI site is to be entered in Column D. It may be entered as:

- once in a quarter, i.e. once in three months
- once in two months
- twice a month
- daily.

Column E and F. The target of PW and infants per session is determined for each site.This is obtained from monthly targets in Form 7 Columns F and G. If the site caters to more than one area, add the targets. If there are two RI sites in a large village, then the monthly target is to be divided by 2.

Example – monthly target for each area from Form 7 columns F and G

Village XYZ has 3 PW & 5 infants and tola XYZ has 1 PW & 2 infants for RI site no 1.

Thus for RI site 1 monthly target will be 4 PW & 7 infants.

Village XYZ has 8 PW & 12 infants with two RI sites 2 and 3

Thus for RI site 2 monthly target will be 4 PW & 6 infants and for RI site 3 also is 4 PW & 6 infants

Note: **For fixed site use daily average of PW and children vaccinated (number vaccinated per month/30)**

Columns G to Q. Injection load for each antigen is to be entered in Columns G to Q. Using the target from **Columns E and F** the individual antigen dose requirement can be calculated using the formula in the boxes.

Column R. The **total** injection load for each site is now available to enter into Column R. This is calculated by adding the number of beneficiaries in **Columns G, H, I, K, L, M, N, O, P and Q.** (Note that OPV, Rotavirus vaccine (where applicable) and Vit A should not be considered as injections.)

Columns S, T and U. These columns show the exact time of RI site functioning for the next 3 months.

Each column is for a month. The day is to be entered as follows:

– Days – Mon, Tue, Wed, Thu, Fri, Sat
– Weeks – 1 to 5

Columns Q, R and S. Columns Q, R and S show the exact time of RI site functioning in the next 3 months.

Each column is for a month. The day is to be entered as follows:

E.g. If the session is held in Month 2 on the fourth Wednesday, the entry will be "Wed 4" in Column S.

Each state can customise this format for their own RI days and immunization schedule.

Method of vaccine distribution to each site is to be entered in the three **Columns V.**

- Information on the mode of transport – two wheeler/three wheeler/four wheeler with its registration number, if possible
- Name of the person transporting the vaccine and his contact number are to be entered.

RI Form 9

Sub Centre area: Per Session Estimation of Vaccines & logistics

TO BE USED WITH FORMAT 8

District: _____ Block/PHC/Urban Planning Unit: _____ SC/UHC: _____

Name of Medical Officer I/C: _____ Mobile no.: _____ Name of IO / ICC:_____ Mobile No._____

Name of ANM: _____ Mobile no.: _____ Name of Supervisor:_____ Mobile No._____

S.No	Location of session site	Estimation of vaccine vials and logistics for each session (At least one vial of each vaccine in each session) This should be filled with the help of Format 8																		
		TT	BCG	DPT	OPV	Penta	RVV	fIPV	MR	JE	Vitamin A	PCV	ADS 0.1 ml	ADS 5 ml	Reconstitution syringes	Paracetamol tablet/syrup	IFA tablets	Zinc tablet / syrup	ORS packet	RI / MCP card	Family welfare materials
Calculations with help of columns in Format 8		G x1.11 /10	H x 2 /10	I x1.11 /10	J x1.11 /20	K x 1.11 /10	L x 1.33 / 10	M x 1.11 /50	N x1.33 /5	O x1.33 /5	(Px 1ml) + {(f x 8) x 2ml)} x 1.11	Q x 1.11 /4	(H+M) x 1.11	(Total of DPT/Penta/ MR /PCV/ JE inj) x 1.11	no. of BCG, Measles & JE vials x 1.11						
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					
	TOTAL																				

Signature of ANM_____ Verified by Medical Officer (Signature):_____

SOPs for using RI Form 9

This format collates the exact requirement of vaccines and logistics (considering wastage) for each session site. This information is calculated using data **from Form 8.**

Columns A and B should be in the same order as in **Form 8.**

Columns C through M, These columns, provide the number of vials/units of vaccine required for each session site. For the calculations, use the information from columns mentioned from Form 8 for each session site. (Number of doses **x** WMF) ÷ no. of doses per vial.

Columns N, O and P - Calculates the requirement of syringes including reconstitution syringes. Calculation is based on number of vials from **Columns C to M of this format.** Remember – only calculate reconstitution syringes for **BCG, MR and JE.**

In the format wastage factors are given in the row below the names of antigens.

Columns Q to V are to indicate the requirement of other logistics for each session site.

Wastage multiplication factor (WMF)–

This is for use in estimation of vaccine and logistics. It is calculated using the following equation:

100 divided by [100 – (wastage %)]

E.g. if wastage is 15 %,

100/ [100-15]

100/85 = 1.18

Permissible wastage percentage

	Number of doses	Permissible wastage %	WMF
Hep B	1	10	1.11
BCG	1	50	2
DPT	2 booster	10	1.11
OPV	3+2 booster	10	1.11
Rotavirus	3	25	1.33
IPV	1	10	1.11
Pentavalent	3	10	1.11
MR	2	25	1.33
PCV	3	10	1.11
TT	2	10	1.11
JE	2	25	1.33
Syringes	As per requirement	10	1.11

RIMP – Form 10 - ANM work plan

This form is used by each ANM to plan her movement for the next 3 months.

The day columns may be customized for each state or district.

Entry of the name of the site and time is to be made against each month.

RI Form 10

Sub Centre - ANM's Workplan

District: _____ Block/PHC/Urban Planning Unit: _____ SC: _____

Name & Mobile no. of Medical Officer I/C: _____ Name & Mobile no. of IO / ICC: _____

Name & Mobile no. of ANM: _____ Name & Mobile no. of Sector Medical Officer: _____

Month	Week	Location of RI sessions with timing					
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1						
	2						
	3						
	4						
	5						
	1						
	2						
	3						
	4						
	5						
	1						
	2						
	3						
	4						
	5						

Signature of ANM _____ Verified by Medical Officer (Signature): _____

RI Form 11 - Sub Centre Communication Plan

Sub centre communication plan for RI	Quarter- 1 / 2 / 3 / 4					RI Form 11
Name of Block:_____	Name of ANM:_____			Name of Subcentre:_____		
Name of Village						
Nane of Session site	1-	2-	3-	4-	5-	6-
Activities						
Miking / drum beating- Name and contact number						
Mosque announcement - Contact person and number - announcement time						
Meetings (Mothers meeting,AWW meeting,etc - Contact person and number - Monthly / weekly)						
VHSC meeting - contact person and number - location - attended by ANM Monthly / weekly -						
School Rallies - school name and contact person with number (once a month in villages on						
Celebrations / Special Days (eg Mothers day, health day etc) - contact person and number						
Wall paintings - locations						
Banners - identify 4 key *locations - Ensure* display at least one day before RI day						
P**ainting competition / Exihibition** - (once a quarter -school name and contact person with number						
Posters - identify 5 key locations (other than Panchayat ghar, Ration store, AWWcentre, Sub centre, Bus stand) - ensure display at least 2 days before RI day						
Pamphlets / Leaflets - available with - contact person name and number - distribute before RI session day						
Counselling aids / job aids (flip books etc.,) - available with - contact person name and number						
Other						
Manpower involvement - with contact number						
Name of ASHA						
Name of AWW						
Name of Mobilizer / CMC						
Name of community influencer						
Name of PRI member						

Date:_____ Sign of ANM:_____ Sign of MO:_____

SOPs for using RI Form 11

Form 11 is the communication plan for a SC.

Information to be filled for up to 6 session sites under a SC. Multiple formats may be used if needed.

A number of activities have been identified; the medical officer should guide the ANM to identify the activities that can be conducted in her areas. It is important to firstly identify the contact person who will coordinate the activity such as a school principal or community leader. Meetings such as **VHSC, Mothers meetings, AWW meetings** are generally held regularly and the tentative dates should be entered in the columns. Follow up on the dates by ANM and if possible the medical officer can support the visits or include them in MO plan.

With IEC material (Posters / banners) the common issue remains who and where the IEC is to be displayed. When reviewing the SC RI microplan discuss the locations appropriateness with ANM and enter the locations in the columns. MO can suggest changes when visiting the area or during subsequent meetings.

Painting competitions / exhibitions require some planning but have a positive impact on the community. Encourage the conduction of such activities.

Pamphlets / leaflets / counseling aids are material that can be placed at the AWC or other locations and used during RI sessions / other meetings.

Having the **names and contact numbers** of frontline workers of each centre will help the ANM to contact them in advance of RI session days. PRI / Community influencers can play a key role in RI and it is essential to identify them in a village or ward area.

Step 5

- **Finalization** of Sub Centre plans and **development** of **final block PHC plan**

The final step in the RI microplanning exercise at the PHC comprises of two components:

- **Component 1** - Review and finalization of the newly updated/ proposed SC RI microplans and finalization of formats and session due lists
- **Component 2** - Development of the final block PHC/UHC RI microplan.

First component: Review of the updated / proposed RI plans

This meeting is to be conducted on the same lines as the first meeting as demonstrated in step 1. The outputs are now focused on the finalization of SC microplans and the development of the PHC microplan. Each ANM should present her sub centre microplans focusing on the following points:

1. Total number of areas identified – any increase or decrease? Form 1
2. Total number of HRAs identified – any increase or decrease? Form 1
3. Demarcation of areas – who will be looking after which area? Form 1 and 2
4. Number of RI sessions planned? Form 7 and 8
5. Are the maps updated? RI Form 2
6. Is sub centre RI microplan now complete?

Each ANM after finalization of the information, plans and forms should compile the information for her SC. Sector medical officers should review the information for their respective areas. After review the MO should approve the ANMs microplans including the number of sessions and the sites.

The ANM can now develop the RI session due lists (Form 6) as per the RI sessions.

Plans from all sub centre are required including those which are vacant and those where ANM is on leave. It is advisable to review 2 to 3 ANMs per day to allow for other activities and maintain quality.

The second component - development of the PHC plan comprises of forms 12 to 18 as enlisted in figure 3.13. Form 12 is made by collating information from individual sub centre plans (RI form 7 and 8). Remember to include the fixed site session at PHC/Block.

Facilitator: MOIC

Participants: Sector MO,ANM, LHV, Health supervisors

Minimum activities at the final PHC meeting

- Review and finalization of SC plans for
  - inclusion of all HRAs
  - special plans for difficult areas
  - adequate deployment of mobilizers
  - adequate session planning
- Compile plans from all SCs to develop block plan
- Prepare vaccine delivery and supervision plan
- Recalculate vaccine and logistics requirement.

Remember

- Every 6 months– Update the available list of all the HRAs in the block/urban area
- During visits to RI sessions – review existing beneficiary and mobilization lists
- Prioritize block/s having large number of HRAs
- Review monitoring reports and data to identify issues
- Facilitate block level review and revision under guidance of DIO in priority blocks
- Follow-up the progress during weekly and monthly PHC meetings

Outputs expected

Availability of the following documents after Step 5:

- Forms 6, 7, 8, 9 ,10 and 11 for each SC
- Forms 12 to 18 for the PHC

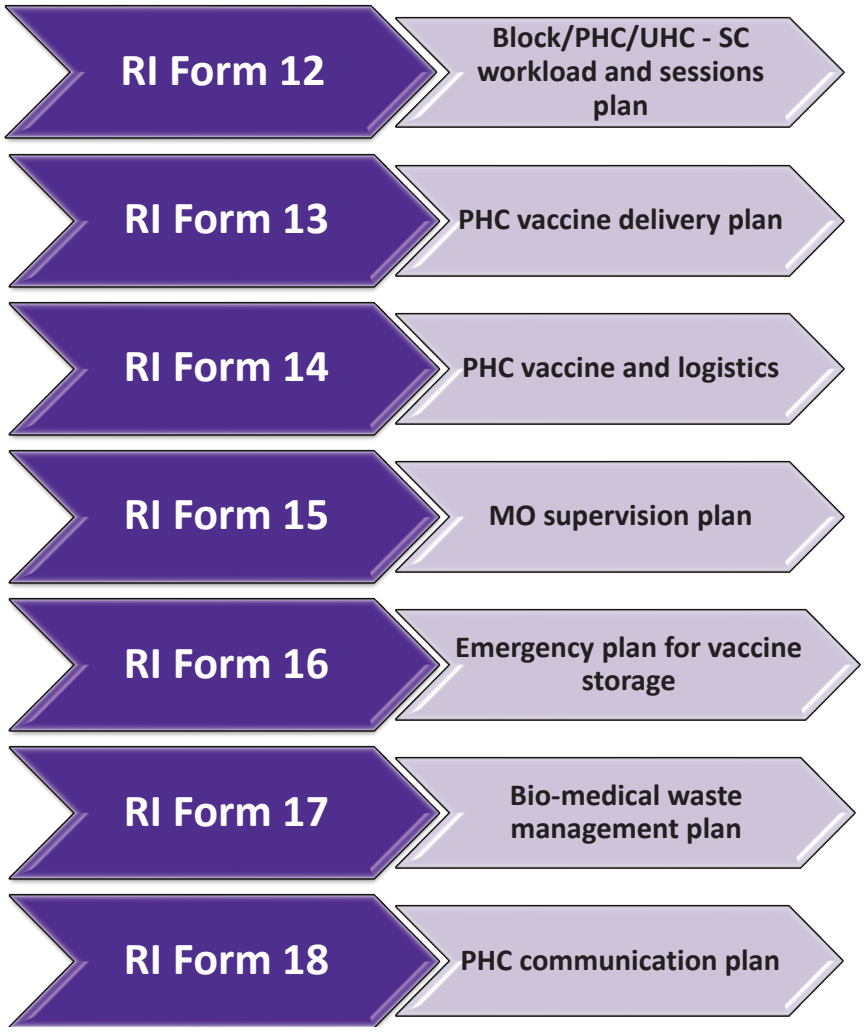
Roles and responsibilities

Personnel	Activities to be performed	Supervisor
MOIC	Coordination of the activity/reviewing each SC plan	DIO
Sector MO	Oversee/review the microplans submitted by ANMs	MOIC
Data manager	Clarify and finalize the names of villages. Data entry for generation of RIMP	MOIC
ANM	Generate SC forms and suggest changes to the reviewing officer	Sector MO

Preparation of a block/PHC/urban planning format

At a PHC or UHC, Seven formats provide overview of a PHC's RI session planning.

Fig. 3.13. Overview of PHC RI Microplan – Forms 12 to 18



RI form 12 – Block workload and sessions plan per Sub Centre

This format is a one page listing of the SCs and the details of the number of beneficiaries, injection load, number of sessions and HRAs. This information is a collation of totals of **Form 8** of each SC. It gives the workload per SC and the details of number of sessions for the PHC.

For fixed sites – at PHC/CHC/UHC – Remember to include as a separate row entry. To determine injection load of the fixed session, use monthly average from tally sheets / register. In very busy centres daily sessions may be held. In form 12 write "Not Applicable"in the columns for information that is not relevant for fixed site.

BLOCK / PHC - Population and injection load

RIMP - FORM 10

BLOCK / PHC / UHC - Subcentre workload and Sessions plan

RI Form 12

District: _____ **Block/PHC/Urban Planning Unit:** _____

Name of IO / ICC: _____ Mobile no.: _____ Name of Medical Officer I/C: _____ Mobile no.: _____

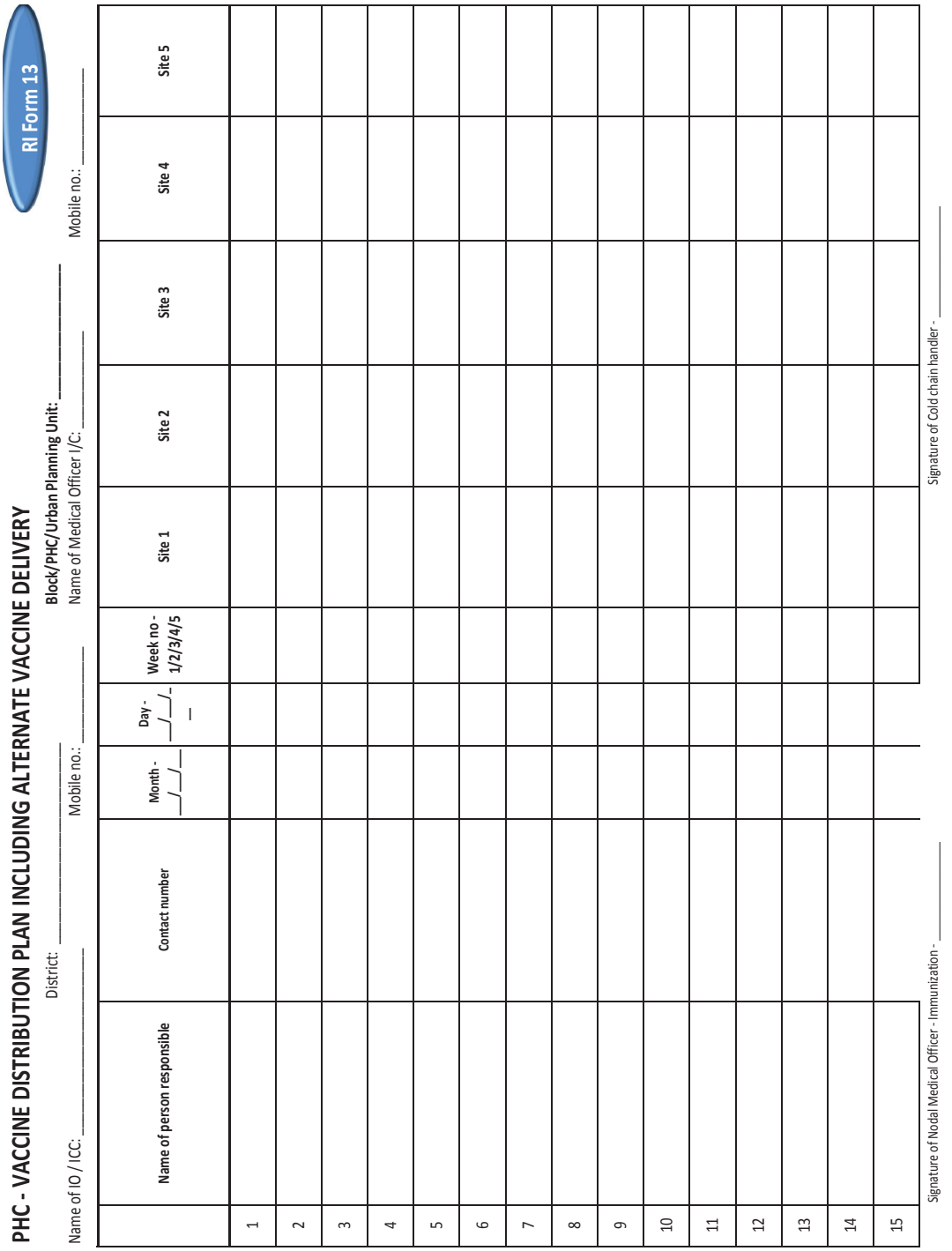
S.No	Name of Sub Centre	Total Population	Estimation of beneficiaries				Monthly Injection Load	Number of Session Sites	Number of sessions per month	Number of polio HRAs	Name of ANM	Contact No
			Annual Target (Based on actual headcount) by ASHA / AWW / ANM etc.		Monthly Target							
			PW	Infants	PW	Infants						
			A	B	C	D	E	F	G	H	I	J
					a/12	b/12						
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
	TOTAL											

Signature of Nodal Medical Officer - Immunization - _____

Signature of Medical Officer I/c- _____

RI Form 13 - Vaccine Delivery Plan including Alternate Delivery.

Vaccine Delivery System refers to the independent person who delivers the vaccine carrier from the PHC to the session site. The ANM has to directly reach the session site in order to maximize the use of her time. It helps to start the session on time, and the HW does not have to come to PHC to collect or return vaccine and other logistics to the PHC at the end of the session. Prepare the AVD plan and route chart for alternate vaccine (and logistics) delivery (AVD) to the session sites from the nearest cold chain storage point for each session day.



RI Form 13

PHC - VACCINE DISTRIBUTION PLAN INCLUDING ALTERNATE VACCINE DELIVERY

Name of IO / ICC: _____ District: _____ Block/PHC/Urban Planning Unit: _____

Mobile no.: _____ Name of Medical Officer I/C: _____

Mobile no.: _____

	Name of person responsible	Contact number	Month - __/__/__	Day - __/__/__	Week no - 1/2/3/4/5	Site 1	Site 2	Site 3	Site 4	Site 5
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

Signature of Nodal Medical Officer - Immunization - _____

Signature of Cold chain handler - _____