Strengthening interpersonal communication skills of front-line workers

ANMs/ASHAs/AWWs are a critical interpersonal link between health providers and community members. They carry out door-to-door visits and are actively involved with the community.For them to be able to effectively communicate with parents/ caregivers and mobilize them to get their children vaccinated, it is important that their interpersonal communication skills be strengthened. They also need to be equipped with appropriate knowledge about vaccines and their benefits, and how to counter prevailing myths and misconceptions on immunization with facts. Details on training of front-line workers are given in Unit 11 on training.

How and when to communicate key messages? Messages need to be appropriately timed: neither too early, lest they be forgotten nor too late for the behaviour to be practiced

Tips for effective IPC skills for communicating with caregivers

Speak clearly

- Use encouraging/helpful non-verbal communication.
- Posture – keep your head level.
- Spend enough time; do not be in a hurry.
- Use responses and gestures to show interest.
- Listen carefully and repeat what the mother says.

Greet

- Smile.Speak in a pleasant voice and tone.
- Maintain eye contact.
- Introduce yourself and your organization.

Ask

- Ask open-ended questions—What? When? Where? Why? How? Who?
  - How many children do you have?
  - Why did you not vaccinate your child?
  - How did you know about the immunization session?

Tell

- What diseases are prevented by vaccination.
- Where and when will the session be held.
- What minor side-effects can occur after vaccination and how these can be managed.

Help: Encourage the parents to come for vaccination by telling them about how to manage AEFIs.

Explain: Use **info-kits** to explain the importance of immunization and the immunization schedule.

Repeat: Use your visit to find out reasons for left-outs and dropouts.

Four key messages to be given to caregivers

- What vaccine was given and what disease it prevents
- What minor adverse events could occur and how to deal with them
- When and where to come for the next visit
- To keep the immunization card safe and to bring it along for the next visit

Holding an effective community meeting

- Identify local community representatives who would participate in the meeting;
- Hold the meeting at a convenient time and place, e.g. on market days, close to places of worship;
- Be prepared with data on the coverage and dropout rates and a map of the health areas with low coverage;
- Provide a comfortable and welcoming environment for the discussion;
- Listen to the community; find out what the community already knows about VPDs and immunization;
- Provide information, using basic language and non-scientific terminology, on the importance of immunization, the status of the immunization programme and where and when services are available. Dispel misinformation and doubts that sometimes surround immunization;
- Encourage the participants to ask questions so that everyone can be better informed;
- Use stories, short plays, songs and visual aids to hold the group's attention and make meetings interesting;
- Involve as many group members as possible in the discussion and ask them to suggest solutions to problems;
- Help mobilize resources for immunization.

Exploring new media and digital communication

The reach of digital media is expanding exponentially and you should exploit every potential communication media. The digital media, either mobile or internet-based, is inexpensive and requires minimal effort. During planning for communication, whether it is for strengthening routine RI programmes or for campaigns, remember to identify media behaviour of the population in your block/under your PHC. As MOs, you have the potential and opportunity to be innovative. There are a number of ways to achieve impactful communication using new digital technologies, as follows:

1. Social media such as Facebook, Twitter, and YouTube are becoming highly popular as preferred modes of communication among the new millennia (young, educated generation).

2. Mobile phones have not only reached every village but also almost every villager, including into women's hands. The potential of reaching the targeted stakeholders is thus enormous. SMS messaging, voiceover messages using celebrities and reminder calls are some simple, direct and affordable ways of reaching the stakeholders with messages.

3. iPads and Notebooks: Digital tools such as iPads or digital Notebooks have now become very powerful tools for IPC sessions to be conducted by front-line workers with the communities. RI counselling using multimedia formats during household visits can be made not only educative but also entertaining.
4. Digitized PHCs: Visitors to PHCs, whether they are patients or their families, can be effectively counselled and exposed to key messages on RI using these digital tools innovatively. A MO who is innovative can make their PHC a model on the use of new media and digital technologies.
5. Data collection and analysis: These digital tools can also be used for purposes of data collection and monitoring and evaluation of different communication interventions for instant results.
6. Training before using: Innovative require capacity building of health service providers to enable effective use.

Appendix: RI form 11: Communication plan for a SC (See Unit 3 for details)

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 - enter date						
School Rallies - school name and contact person with number (once a month in villages on rotation)						
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						
Painting competition / Exhibition - (once a quarter -school name and contact person with number						
Posters - identify 5 key locations (other than Panchayet 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: _____

Notes:

UNIT-10

Vaccine Preventable Diseases and VPD surveillance

Learning objectives

- *Define surveillance and list its uses*
- *Describe standard case definitions of various vaccine preventable diseases*
- *Explain steps in conducting surveillance and outbreak response.*

Key Contents

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Reporting network: the backbone of a surveillance system	223
Types of surveillance systems functioning in India	224
Outbreak investigation, response and control	226

Surveillance for vaccine preventable diseases

10

Surveillance is data collection for action. It is defined as the ongoing systematic collection, analysis, interpretation and dissemination of data about cases of a disease and factors influencing disease behaviour, which is used as a basis for planning, implementing and evaluating disease prevention and control activities, including immunization. Surveillance is the basic tool for understanding the epidemiology of a disease. Its key objectives are to trigger public health control measures, identify outbreaks and assess the effectiveness of prevention programmes.

Key elements of an effective surveillance system

These are:

- detection and notification of disease conditions
- investigation and confirmation (epidemiological, clinical and lab) of VPD cases
- collection, analysis and interpretation of data
- feedback and dissemination of results
- prevention and control responses.

Surveillance data on VPDs can monitor the impact of vaccination on disease incidence, identify HRAs and identify outbreaks.

Uses of VPD surveillance

Disease surveillance enables the following:

- predicting or detecting disease outbreaks for containment (**what** disease is occurring)
- identifying high-risk populations (**who** gets the disease)
- identification of HRAs requiring special attention, and where system performance is poor (**where** the disease is occurring)

- determining the frequency of occurrence of a disease in the community and magnitude of the problem (**when** the disease is occurring and **how many** get the disease)
- identifying underlying causes (or risk factors) of the disease (**why** the disease is occurring)
- guiding response activities, including immunization (**how** the disease can be prevented, controlled or eliminated).

Prerequisites for effective surveillance

- Standard case definitions (to ensure uniformity in reporting)
- Recording and reporting system (to ensure regularity in reporting)
- List of all the reporting units (to ensure completeness in reporting)

The quality of surveillance data depends upon correct diagnostic criteria, timeliness and completeness of reports.

Case definitions of VPDs

The case definitions of VPDs are as follows:

- ***Polio:*** Acute flaccid paralysis (AFP) is defined as sudden onset of weakness and floppiness in any part of the body in a child < 15 years of age, or paralysis in a person of any age in whom polio is suspected. **(WHO)**
- ***Measles:*** Any person in whom a clinician suspects measles infection,

  or

  Any person with fever **and** maculopapular rash, i.e. non-vesicular

  and

  cough, coryza (runny nose), or conjunctivitis (red eyes). **(WHO)**
- ***Diphtheria:*** A suspected case of diphtheria is defined as an illness of the upper respiratory tract characterized by the following:
  - laryngitis or pharyngitis or tonsillitis,

    and

  - adherent membranes of tonsils, pharynx and/or nose. **(WHO)**
- ***Pertussis:*** A suspected case of pertussis is defined as a person with a cough lasting for at least 2 weeks, with at least one of the following:
  - paroxysms (fits of coughing)
  - inspiratory whooping
  - post-tussive vomiting (vomiting immediately after coughing)
  - without other apparent causes. **(WHO)**

- ***Neonatal tetanus:*** Any neonate with a normal ability to suck and cry during the first 2 days of life, and who thereafter cannot suck normally between 3 and 28 days of age and becomes stiff or has convulsions/spasms (jerking of the muscles), or both. **(WHO)**
- ***Tuberculosis:*** A child with fever and/or cough for more than 2 weeks, with loss of weight/no weight gain and history of contact with a suspected or diagnosed case of active TB disease within the last 2 years. **(WHO)**
- ***Bacterial meningitis:*** Any person with sudden onset of fever (> 38.5 °C rectal or 38.0 °C axillary)

  and

  one of the following signs: neck stiffness, altered consciousness or other meningeal sign **(IDSP).**
- ***Hepatitis B:*** An acute illness typically including acute jaundice, dark urine, anorexia, malaise, extreme fatigue and right upper quadrant tenderness.
  - Biological signs include increased urine urobilinogen and >2.5 times the upper limit of serum alanine aminotransferase.

  Note: Most infections occur during early childhood. A variable proportion of adult infections are asymptomatic. **(IDSP)**
- ***Japanese Encephalitis:*** A person of any age, at any time of the year with acute onset of fever and change in mental status (including symptoms such as confusion, disorientation, coma or inability to talk)

  and/or

  new onset of seizures (excluding simple febrile seizures).

  Other early clinical findings may include an increase in irritability, somnolence or abnormal behaviour greater than that seen with usual febrile illness. **(IDSP)**

Reporting network: the backbone of a surveillance system

Efficient and reliable reporting network and notification systems are vital for any disease surveillance. In many developing countries, the number of cases that are reported into the system is an underestimation of the actual disease burden, for the following main reasons:

- ***Community level:*** Not all cases seek healthcare at the designated reporting sites (this is called under ascertainment).
- ***Health facility level:*** Failure of the reporting site to adequately report suspected cases that have sought medical advice (under-reporting). The common reasons for under-reporting include lack of knowledge of case definitions , lack of appreciation of the importance of reporting , lack of motivation, competing priorities and complexity of the reporting procedure.

- All ***health-care delivery sectors not included in the reporting network*** (e.g. private sector not involved, ISM practitioners not involved, etc.)

It is difficult to address under-ascertainment. However, under-reporting can be addressed by diligently selecting the reporting sites, creating awareness of the importance of case reporting and regular monitoring to verify the quality and completeness of reporting. The health facility selected for VPD surveillance should:

- be adequately motivated to participate in the surveillance with the understanding of its importance
- serve the population of interest
- have medical staff sufficiently specialised to diagnose, treat and report cases of the diseases under surveillance.

Various types of surveillance systems functioning in India

Surveillance system for polio and other VPDs

The country has established an efficient surveillance system for polio with technical, operational and monitoring support from WHO-NPSP. This support for countrywide AFP surveillance is made through its strong field presence and a well-distributed network of reporting sites.

The reporting network for AFP involves both public and private sector health facilities and has established mechanisms for case investigation, reporting and data management. AFP surveillance has proved to be one of the best surveillance systems globally and functions beyond the globally accepted quality standards. Details of operational protocols are available in the AFP surveillance field guide, also popularly known as Red Book.

Utilizing the AFP surveillance system for surveillance of other VPDs

To capitalize on the existing infrastructure and investments already made in the Polio Eradication Initiative, the platform of the AFP surveillance system is being modified to generate valuable epidemiological information for other VPDs. A laboratory-supported surveillance system for VPDs has been designed to capture epidemiological data on measles, rubella, diphtheria, pertussis and neonatal tetanus.

A measles-rubella surveillance system has been established across the country with 14 laboratories in the network. National Institute of Virology, Pune and King Institute of Preventive Medicine (KIPM), Chennai are designated as reference laboratories. The operational protocols for measles-rubella surveillance are available in the "Measles Surveillance and Outbreak Investigation– Field Guide".

A laboratory network for surveillance of other VPDs is being established. The Christian Medical College at Vellore has been designated to serve as the reference laboratory for the VPD surveillance laboratory network and state-specific laboratories functioning under the supervision of the reference laboratory are expected to test the samples collected from suspect cases. Technical and operational details of the laboratory-supported case-based VPD surveillance system are available in "Surveillance for Vaccine Preventable Diseases – Field Guide" developed by WHO in coordination with the GoI.

Integrated Disease Surveillance Project

IDSP is a surveillance system wherein data generation, compilation, analysis and feedback to actions take place at district level and flow upwards to the state surveillance unit (SSU) and central surveillance unit (CSU). IDSP has an administrative mechanism in the form of surveillance committees and surveillance units at district and state levels headed by a surveillance officer and supported by an epidemiologist, microbiologist, data entry operator and data managers. Implementation is intended to uncover the burden of infectious diseases and detect early warning signals for outbreaks based on syndromic reporting right from the population level. Gaps exist in capturing of data from the private sector.

Laboratory confirmation of cases and outbreaks is another important component of IDSP that feeds into Form L at the district level. In addition, a reference laboratory network has been established in nine states by utilizing the existing functional laboratories in the medical colleges and other facilities which provide diagnostic services.

Central Bureau of Health Intelligence (CBHI)

CBHI, under the Directorate General of Health Services (DGHS), is an agency involved in collection, compilation, analysis and dissemination of information on a broad range of indicators related to health status and health services in the country. It is the national nodal institution for health intelligence. CBHI has a web-based data entry portal for collation of data at the national level. It regularly brings outs an annual publication in the form of National Health Profile based on the health data collected from all health directorates of states and union territories.

A sensitive and reliable VPD surveillance system can become an important tool for generating valuable epidemiological data which provides guidance to national policy-makers to identify specific national challenges and formulate evidence-based recommendations on immunization.

Awareness and skills of health staff are major factors for high sensitivity and quality of a surveillance system. All these systems are dependent on the district and sub-district level health staff. The states have to ensure capacity building of the health-care providers/ surveillance staff, monitoring and evaluation of the key components of surveillance, data analysis and providing feedback.

Outbreak investigation, response and control

An **outbreak** is defined as the occurrence of an illness in a community, clearly in excess of the expected numbers. Usually, an outbreak is limited to a small focal area. When an outbreak covers a larger geographic area and has more than one focal point, it is termed as an epidemic.

Outbreaks are defined differently for different VPDs. For diphtheria, polio, neonatal tetanus or JE, even a single case is defined as an outbreak, whereas for measles and pertussis, a sudden increase in the number of cases is considered to be an outbreak.

Steps in outbreak investigation

Prompt and timely action during an outbreak is critical for minimizing the damage and maintaining public trust in health and immunization services. The emphasis should be on saving lives. Do not wait for confirmation of a suspected outbreak, immediately provide logistic support to the field teams. Once the cause of the outbreak is confirmed, do not further waste laboratory support for diagnosing every case, since standard case management for epidemiologically-linked cases does not require laboratory confirmation.

Step 1: Confirm the outbreak

Confirmation of an outbreak is done through two related steps. Firstly, you have to visit the area concerned and confirm the diagnosis of as many reported cases as possible. Next, you should ascertain its geographical spread through a preliminary search.

- **Confirm the diagnosis** by:
  - ***Clinical criteria:*** According to the standard case definition using information obtained by history and examination.

- ***Epidemiological association:*** If an outbreak has been confirmed, and similar cases in the same area in the same period of time are reported by HWs but not investigated individually, they may be confirmed by epidemiologically-linked association with confirmed cases.
- ***Laboratory tests:*** For VPDs subject to eradication or elimination, collect laboratory specimens from every suspect case (e.g. stool sample from each AFP case). For VPDs subject to control, collect specimens from a sufficient number of cases (e.g. five blood samples in case of a measles outbreak) to confirm the outbreak. However, no laboratory specimens are required for neonatal tetanus.

- **Ascertain the geographical extent** of the outbreak to the surrounding villages/ blocks. The search for additional cases must include visits to:

  Health facilities: Talk to the doctors and nurses to see if they are seeing suspected cases of the VPD. Visit hospital wards and outpatient departments and search all patient registers for cases that fit the standard case definition.

  The community: Visit the area from where cases have been identified. Talk to volunteers and other influential persons in the community. If feasible, organize a rapid house-to-house search of the affected area(s) to search for similar cases. Identify key informants in each village/ward for prompt information about any cases.

Step 2: Conduct house-to-house searches to find additional cases and provide case management

Train and assign HWs to conduct house-to-house searches to find the cases in the designated area. Ensure all are aware of the case definitions and ensure monitoring of this activity.

Step 3: Line list and notify the cases

Enlisting all cases is important as it collates all relevant information.

Step 4: Describe the outbreak

Describe the outbreak in terms of time, place and person.

Step 5: Analyze the data to:

- Confirm the outbreak:
  - Are the number of cases reported greater than the number expected for this period (e.g. threshold)?
  - What proportion of cases fulfill the case definition?

- Define the extent of the outbreak (time, place and person).
- Measure the severity of the outbreak (what proportion of confirmed cases were hospitalized, suffered complications or died).

Step 6: Use the data for action

Use data on the various components of the immunization system such as coverage, status of the cold chain, training and availability of personnel to determine the probable causes of the outbreak.

Step 7: Write the report

After conducting the outbreak investigation, prepare a short comprehensive report.

Step 8: Give feedback

Provide feedback to all levels (community/SC/PHC/CHC/district) on the outcomes of the VPD outbreak investigation, in order to ensure that all stake holders are aware of the reasons for the outbreak, the actions initiated and the plan to prevent future outbreaks.

Step 9: Initiate action

In all VPD outbreaks, effective case management and followup of cases is a priority. Thereafter, conduct activities for strengthening and raising awareness of RI.

For further details refer to operational manuals / guidelines of VPD surveillance, measles and AFP.

UNIT-11

Capacity building of health functionaries in immunization

Learning objectives

- *Describe the importance of capacity building of health functionaries and the target groups*
- *Enlist different mechanisms for conducting immunization training*
- *Describe the guidelines, curricula and steps for conducting intensified immunization training of frontline workers.*

Key Contents

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Capacity building of health functionaries in immunization

11

Regular capacity building of health functionaries at the village and SC level is essential to ensure sustained utilization of quality immunization services by the community. As an MO, it is your duty to ensure that all the health functionaries in your PHC have adequate knowledge and skills to provide quality immunization services, including social mobilization functions.

The following health functionaries need to be regularly trained in immunization at the block/PHC level:

- HWs or vaccinators
- HSs
- Social mobilizers such as ASHAs and AWWs
- Vaccine and Cold-chain handlers
- Data handlers.

Training mechanisms

Different mechanisms which can be used to train the health functionaries are as follows:

- Half day training of front-line workers at PHC/block level once every 6 months
- Review meeting at the block/PHC held every fortnight/month/quarter
- Supervisory visits to the health centres, session sites and the community.

These are in addition to the regular training courses imparted by the district or state. Overview of the regular training courses available under the immunization programme is given in Table 11.1.

Table 11.1.Overview of regular training courses available under the immunization programme

Category	Duration	Venue	Training materials
MOs – Immunization	3 days	District/regional/state training centre	Immunization Handbook for MOs, Facilitators' Guide and Training kit
MOs –RI microplanning	2 days	State level TOT followed by cascaded training at district and sub-district level	Material shared during state-level workshops
HWs	2 days	District training centre/ ANMTC	Immunization Handbook for HWs and Facilitators' Guide
Frontline Workers – Immunization	Half day	Block/PHC level	Info-kits for HWs and ASHAs/ AWWs,Facilitators Guide for Intensified Immunization Training of Frontline Workers
Cold-chain handlers	2 days	District training centre/ ANM Training Centre	Handbook for Vaccine and Cold-chain Handlers

Intensified immunization training of frontline workers: an overview

This training course was provided by GoI with WHO-India (NPSP) support to the frontline workers in nine priority states during 2013. It is recommended that MOs of all blocks/ PHCs should use these guidelines, curricula and methodologies to regularly train frontline workers, i.e. ANMs, LHVs, HSs, ASHAs, AWWs,HWs (male), urban HWs, link persons, etc. An overview of the training is at Table 11.2.

Table 11.2 .Overview of immunization training for ANMs and LHVs

Participants	Block level facilitators (MO/BMC)	ANMs, LHVs, health supervisors	ASHAs, AWWs and others*
Venue of training	District level	Block level	Block level
Duration	One day TOT	4 hours	3 hours
Batch size	20–25	25–30	30–40 (ASHAs and AWWs under the same SC area should be called together along with the concerned ANM)
Facilitators	DIO, SMO (WHO), other partners, RRT members	Block level MO (2 per batch)	Block level (2 per batch) MO/LHV/ BMC
Contents of training	Role of facilitator and types of training, immunization schedule and FAQs, social mobilization and IPC, planning and managing immunization sessions, injection safety, AEFIs, records and reports	Immunization schedule and FAQs, social mobilization and IPC, planning and managing immunization session, injection safety, AEFIs, records and reports	Immunization schedule and FAQs, role and responsibilities, improving reach of immunization services and IPC skills required
Training material	Facilitators' guide	Info-kit for HWs	Info-kit for ASHAs, AWWs
Training methods	Discussions, roleplays, group exercises, films on immunization and IPC		

**** Others include HW (male), urban HW, link person, etc.***

TOT – training of trainers; RRT – rapid response team; FAQ – frequently asked questions

Roles and responsibilities of MOIC block/PHC as immunization manager

- Assess training load and prepare a training calendar for the year, marking the dates of the meetings and other opportunities that can be used for training.
- Select topics from the training material which are relevant for the health functionaries based on assessments through data analysis of routine reports and RI monitoring/ supervision.
- Prepare an agenda and allocate sessions to the facilitators at PHC/block level.
- Inform the participants in advance so that they can come prepared with their questions.
- Arrange for all equipment and supplies required during the training.
- Organize the venue and logistics.
- Conduct training as per the calendar.
- Submit a report of the training conducted with muster roll to DIO.
- Plan and conduct catch-up training for absentees.
- Continue to provide follow-up and on the job training to front-line workers during supervisory visits and review meetings.

Role and responsibilities of MO as the facilitator

- Positive attitude is required at all times to effectively carry out your roles.
- Encourage participants to ask questions and make comments.
- Use examples from your own experience and ask participants for examples from their experience.
- Model good communication skills, speak clearly and vary the pitch and speed of your voice.
- Use interactive training methods for training such as demonstration and hands-on practice, brainstorming, group discussions, role plays, films on immunization and IPC, question and answer technique, posters and presentations and flip charts or black/ white board.
- Praise/compliment each participant for comments, participation and contributions.
- Always summarize, or ask a participant to summarize what was discussed in the session.
- Keep the group on track.
- Encourage participants to explore how the skills they are learning can help them to improve immunization coverage.

Note: Various planning (annxure 1) and reporting formats (annxure 2) used for this training are annexed in this unit.

Training programme for immunization training of ANMs and LHVs

Learning objectives

At the end of the training, the participants should be able to:

- explain National Immunization Schedule and the frequently asked questions (FAQs);
- list the reasons and solutions for left-outs and dropouts, and key IPC messages;
- plan and conduct immunization sessions using injection safety measures;
- use recording and reporting forms correctly.

The agenda for this training is given in Table 11.3.

Table 11.3. Agenda for immunization training of HWs (ANMs and LHVs)

Session No.	Time	Session
1.	10:00–10:15	• Welcome, introduction of participants and pre-test • Sharing of RI issues from the RI monitoring reports
2.	10:15–10:45	• National Immunization schedule • Frequently asked questions
3.	10:45–11:30	Social mobilization and IPC: • Tracking left-outs and dropouts with emphasis on HRAs • Key IPC messages
4.	11:30–12:30	Planning and managing immunization sessions: • Planning and preparing for immunization session • Arranging immunization session • Conducting immunization session • Injection safety • AEFIs - including the use of Adrenaline in AEFI
5.	12:30 -13:20	Records and reports (10 minutes each): • MCP card,counterfoils and tracking bag • MCH/Immunization/MCTS register • Name-based list of due beneficiaries and Tally Sheet • Monthly Progress Report (HMIS report)
6.	13:20–13:40	Film on RI
7.	13:40–14:00	Open discussion, post-test, feedback and wrap-up

List of items required for the training

- Info-kit for HWs and stationary for all participants
- White board with marker pens/flip charts with tripod stand
- TV, DVD player/LCD projector and screen
- Vaccine carrier with 4 conditioned ice packs and vaccine vials in the zipper polythene pack
- AD disposable syringes – 0.1 ml and 0.5 ml
- Functional hub cutters – 4
- Waste baskets with Red Plastic Bag – at least 1
- Waste basket with Black Plastic Bag- at least 1
- MCP/RI cards – filled
- Tracking bag
- RCH/Immunization/MCTS registers –filled
- Due list cum tally sheets –filled
- HMIS reporting format for SC–filled.
- Use of adrenaline in AEFI

Detailed guidelines for conducting HW training

Session 1: Welcome, introduction and sharing of key RI issues

Time: 10:00–10:15	**Registration:** • Register all participants by asking them to sign in Muster roll (Annex2). • Give info-kit and other stationary to each participant. • Make a note of the number of expected participants who did not attend. • Plan to train them during catch-up sessions.
Method: Interaction and discussion	**Introduction and pre-test:** • Ask each participant to introduce herself/himself briefly by giving her/his name, place of work and years of experience. Also, one personal detail such as a hobby or interest they have outside of work. • Ask pre-test questions. **Sharing of RI issues from monitoring reports:** • Share key RI issues identified during monitoring visits. Ensure that these issues are addressed during the training.

Session 2: National Immunization Schedule and frequently asked questions

Time: 10:15–10:45	**Steps:**
Method: Discussion	• Discuss the National Immunization Schedule by asking participants and later ask them to check from info-kit. • Discuss FAQs by asking each participant to read one question and answer by taking turns. • Explain to clarify their doubts.

Session 3: Social mobilization and interpersonal communication

Time: 10:45 – 11:30	**Steps:**
Method: Group discussion and role plays	• Discuss definition of dropouts and left-outs (5 mins). • Ask participants about the common reasons and solutions for dropouts and left-outs based on their experience. List them on the flip chart (15 mins). • Divide the participants into two groups to discuss the following (20 mins): ▪ Ask Group 1 to move to the far corner of the room to represent that they are living in a remote hamlet without any SC in their village. Outreach sessions are rarely held in their village. Explain that their children are one type of "left-outs", i.e. they are hard to reach geographically and have difficult access to services. Ask them to discuss the reasons why their children do not get vaccinated and also suggest some possible solutions. ▪ Now turn to Group 2 and explain that their children started the vaccination schedule but have not completed it and no longer go to the session. Explain that their children are "dropouts." Ask them to discuss the reasons why their children dropped out and to also suggest some possible solutions. • Ask each group to present/role play in the plenary (15 mins). • Summarize the session by reminding participants of the 4 key IPC messages (5 mins).

Session 4: Planning and managing an immunization session

Time: 11:30–12:30	**Steps:**
Method: Discussion, role plays, demonstration of injection safety equipment	• Discuss components of the Microplan by asking participants (5 mins). • Discuss what all preparations are required before an immunization session (5 mins). • Ask for volunteers to play the role of ANM and caregiver with beneficiary. • Ask them to present a roleplay on conducting an immunization session (by using the session site equipment and logistics) (10 mins). • Ask all participants to observe the role play and check from the info-kit whether all steps are being followed. Make a note of missed steps to be discussed after the roleplay (15 mins). • Demonstrate the use of AD syringe, hubcutter and waste disposal guidelines (10 mins). • Discuss definition of AEFIs and their types; common programme errors and how to prevent them; how to manage and report AEFIs (15 mins) and ensure entry in the block AEFI register.

Session 5: Records and reports

Time: 12:30–13:20	**Steps:**
Method: Brain storming, group work, discussion, demonstration	• Ask participants what are the various records and reports related to the immunization programme (5 mins). • To each group of 4–5 participants, distribute filled in: o MCP card o RCH/Immunization/MCTS register o Due list and Tally sheet o Monthly Progress Report (HMIS report). • Ask them to identify the gaps and discuss any issues faced. • Demonstrate use of tracking bag for keeping counterfoils.

Session 6: Film on Routine Immunization

Time:	**Steps:**
13:20–13:40	• Ask participants to note key messages from the film for improving quality of immunization services.
Method:	• Show the film.
Film	

Session 7: Open discussion, post-test, feedback and wrap-up

Time:	**Steps:**
13:40–14:00	• Ask post-test (same as pre-test) and feedback questions from the participants.
Method:	• Ask participants to enumerate key actions they would take to improve coverage and quality of services after training.
DIscussion	• Clarify any doubts of the participants and close the session.

Training programme for immunization training of ASHAs and AWWs

Learning objectives:

At the end of the training, the participants should be able to:

- Describe the importance of immunization and the role of ASHA and AWW in the immunization programme
- List the vaccines available under National Immunization Schedule
- List the reasons for left-outs and dropouts and how to deal with them
- Keyinterpersonal messages and skills to communicate with the caregivers.

Agenda for this training is given in Table 11.4.

Table 11.4. Agenda for immunization training for ASHAs and AWWs

S No	Time	Session
1.	10:00–10:15	Welcome,introduction of participants and pre-test
2.	10:15–10:30	Importance of immunization and National Immunization Schedule
3.	10:30–10:45	Role of ASHA/AWW in immunization programme
4.	10:45–12:00	**Social mobilization and IPC:** • What and why are dropouts and left-outs? How to reach them? • IPC skills required • Preparing/updating due lists • Tracking left-outs and 0dropouts • Key IPC messages during o house-to-house visits o immunization sessions
5.	12:00 –12:20	Film on IPC in RI
6.	12:20–12:40	FAQs regarding immunization
7.	12:40–13:00	Open discussion, post-test, feedback and wrap-up

List of items required for the training

- Info-kit for ASHA/AWW and stationary for all participants
- White board with marker pens/flip charts with tripod stand
- TV, DVD player/LCD projector and screen
- Due-list cum tally sheet – filled.

Detailed guidelines for conducting ASHAs and AWWs training

Session 1: Welcome and introduction of participants

Time: 10:00–10:15	**Registration:** • Register all participants by asking them to sign in Muster roll (Annex2). • Give info-kit and other stationary to each participant. • Make a note of the number of expected participants who did not attend • Plan to train them during catch-up sessions.
Method: Interaction and discussion.	**Introduction and pre-test:** • Welcome and ask each participant to introduce herself briefly by giving her name, place of work and years of experience. Ask pre-test questions.

Session 2: Importance of immunization and National Immunization Schedule

Time: 10:15–10:30	**Steps:**
Method: Discussion	• Explain the importance of immunization and the VPDs prevented. • Discuss the National Immunization Schedule by asking participants and later ask them to check from info-kit.

Session 3: Role of ASHAs/AWWs in the immunization programme

Time: 10:30–10:45	**Steps:**
Method: Brainstorming	• Ask each participant to tell one responsibility of an ASHA/ AWW in immunization and write their responses on a flip chart. • Group them into groups for enumerating their responsibilities before, during and after immunization session and check from info-kit for any missed points.

Session 4: Social mobilization and interpersonal communication

Time: 10:45–12:00	**Steps:**
Method: Brainstorming, discussion, roleplays, exercises	• Discuss the definition of dropouts and left-outs (5 mins). • Ask participants about the common reasons for dropouts and left-outs based on their experience. **List them on the flip chart** (15 mins). • Check from info-kit to see if any reason is missed. • For each reason, ask and discuss the solutions and cross check from info-kit (15 mins). • Discuss IPC skills required for the social mobilizers by referring to the info-kit (5 mins). • For roleplays, ask for 8–10 volunteers, 4–5 to act as caregivers and other 4–5 to act as ASHAs/AWWs. • Ask other participants to observe the IPC skills used during roleplays and comment on the same after the role plays. • Call a pair of one caregiver and one ASHA/AWW to the front. Ask them to enact the IPC related to RI issue/s (dropouts and left-outs) during house-to-house visits and at session sites. • Then ask other pairs to come one by one and discuss different issues not covered by earlier groups (25 mins). • Summarize the session by revising the key IPC messages. • Discuss tools for tracking left-outs and dropouts. • Give an exercise on filling due lists and Tally sheet (10 mins).

Session 5: Film on interpersonal communication in routine immunization

Time: 12:00–12:20 **Method:** Film	**Steps:** • Ask participants to note key messages from the film for improving coverage. • Show the film.

Session 6: Frequently asked questions on immunization

Time: 12:20–12:40 **Method:** Discussion	**Steps:** • Ask participants to read the FAQs and answers one by one. • Explain and clarify their doubts.

Session 7: Open discussion, post-test, feedback and wrap-up

Time: 12:40–13:00 **Method:** Discussion	**Steps:** • Ask post-test (same as pre-test) and feedback questions from the participants. • Ask participants to enumerate key actions they would take to improve coverage and quality of services after training. • Clarify any doubts of the participants and close the session.

Pre and Post test questions

For HWs:

1. Name the VPDs under the UIP.
2. What all vaccines should be given to a child for full immunization by 1 year of age and by 2 years of age?
3. What tools are available for tracking dropouts and left-outs?
4. What are the four key IPC messages that should be given to the caregivers?
5. What are minor AEFIs and how to manage them?

For ASHAs and AWWs:

1. Name the VPDs under the UIP.
2. What all vaccines should be given to a child for full immunization by 1 year of age and by 2 years of age?
3. What tools are available for tracking dropouts and left-outs?
4. What are the four key IPC messages that should be given to the caregivers?

Role of ASHA, AWW and social mobilizers in the immunization programme

Planning for immunization

- Enumerate all the pregnant women and children and their immunization status.
- Help the ANM to identify hard to reach areas and underserved populations.
- Help in planning the site, day and time of the session in the village.
- Share the list of newborns in the area with the ANM every month.
- Help in preparing the due list of beneficiaries for your area/village.
- Visit households to inform the due beneficiaries of the vaccination date, time and site.

During the immunization session

- Ensure that all due beneficiaries are brought to the session site for immunization.
- Assist the ANM in conducting the immunization session(control the crowd, assist in recording, etc.).
- Deliver the four key messages about immunization to the caregivers.
- Ask the beneficiaries to wait for 30 minutes at the session site after immunization.
- Prepare the due list for the next session.

After the immunization session

- Report any case of high fever, any allergic reaction or convulsions after immunization to the ANM and ensure the treatment.
- Visit the houses of dropouts and left-outs to counsel the mothers to immunize their children.

"How to conduct a roleplay" with a sample illustration

- Select a group of six volunteers and take them out of the hall.
- Share with them the story plot given below.
- Instruct them to prepare a roleplay based on the situation.
- Give them 10 minutes to present the roleplay.
- Before the roleplay begins, ensure the following:
    - Participants are seated and attentive;
    - Ask everyone to observe the roleplay closely so that it could be discussed later;
    - Take note of the HW's role.
- Ask them to enact out the roleplay.

A sample role play is given below (please note that in the case study below, the example of a female child has been deliberately given to reinforce the point that a female chid is equally important and needs equal care as a male child).

Rani is a HW. She goes to Phalguni's house. She wants to remind the family about the immunization session the next day and the visit of the ANM. Also, she has to explain the importance of vaccinating a child and the benefits of immunization. Phalguni's 5-month-old daughter is suffering from diarrhoea and fever. The entire family is under great stress. Rani is trying to draw their attention. She fails and the discussion could not start.

Rani: (Knock knock – she is knocking at the door of Phalguni's house). Phalguni's sister Phoolwati opens the door.

Rani: (Comes in through the door.) "Phoolwati, listen, the ANM behenji is coming to the village tomorrow and she will give vaccines to the children. I want to talk to you all about this".

Phoolwati: "Dekho Rani, we all are very tense and busy now".

There is loud crying from inside. Phalguni is crying. The others in the house are trying to pacify her. Rekha, her sister-in-law, is running around to get a clean cloth to wipe the baby. Someone else is running to fetch a wiping mop.

Rani: "Listen, I have come to tell you something very important. The ANM will vaccinate children of the village tomorrow. You have so many little children in the house. You all must definitely come."

Nobody is listening to Rani. She is looking around at all of them.

Rekha: "Bhabhi, don't cry. Munni will be alright. Bhaiyya,why don't you run and get the nurse behenji".

Rani: "Phoolwati, if you don't want to listen it is really your headache. How does it matter to me? I will tell the Pradhanji, and I have to visit other houses too. Had you taken the advice of nurse behenji seriously your child would not have been so sick in the first place."

The father of the child is running out and Rani leaves.

Some questions after the role play:

- What did you see?
- What mistakes did Rani make?
- What should she have done?

Discuss and brief the HWs on the various attributes and skills a communicator should possess and use when dealing with families and the community at large. Now ask them to enact the same role play (with a changed scenario).

Rani: (Knock knock – she is knocking at the door of Phalguni's house). Phalguni's sister Phoolwati opens the door.

Rani: (Comes in through the door.) "Phoolwati, listen, the ANM behenji is coming to the village tomorrow and she will give vaccines to the children. I want to talk to you all about this".
Phoolwati: "Dekho Rani, we all are very tense and busy now".
There is loud crying from inside. Phalguni is crying. The others in the house are trying to pacify her. Rekha, her sister-in-law, is running around to get a clean cloth to wipe the baby. Someone else is running for fetching a wiping mop.
Rani: "Oh! What happened? Why is the baby crying? Is everything all right?"
Phoolwati: "Rani, Phalguni's baby is very sick. She has been having watery stools for the last 3 days and also has fever. We all are very worried for her".
Rani: "Don't worry, she will be fine. May I have a look at her?"
Phoolwati: "Surely.She is in the room. Phalguni has been crying, we have tried everything....don't know what to do. Come in".
Rani: (Goes into the room, and consoles and comforts Phalguni) "Don't worry, she will be fine. Have you given her ORS?"
Phalguni: "No Rani, she has become so weak. She is not even taking my milk".
Rani: "ORS is very safe. Please give it to her. It will help her recover fast". (Rani takes out an ORS sachet from her bag and gives it to Phalguni. She tells her how to prepare the ORS solution and how to feed the baby). "Also continue to breastfeed the baby, there is no substitute for mother's milk. But you should get her vaccinated tomorrow. The fever is mild and vaccination will not harm her; rather, it will protect her from life-threatening diseases. Bhaiyya, please come along with me. We need to call in the doctor immediately".
Both of them leave to call the doctor.

Some questions after the role play:

- What did you see?
- What did Rani do differently this time?
- What do we learn from this?

Annexures –Planning and reporting formats

Annexure 1

Format for planning and scheduling the immunization training of front-line health workers

State: ____________________ District: ____________________ Block / Urban Planning Unit: ____________________

Sr. No.	Category of training* (Encircle)	Date of training session	Venue of training	Time of training session	Number of participants expected to attend						Name of trainer	Designation and contact details of trainer
					LHV / HS	ANM	ASHA	AWW	Others#	Total		
	1 / 2											
	1 / 2											
	1 / 2											
	1 / 2											
	1 / 2											
	1 / 2											
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	1 / 2											
	1 / 2											
	1 / 2											
	1 / 2											
Total												

* 1=LHV/ HS/ ANM; 2=ASHA/ AWW/ Others#

Others includes HW(Male), Urban health worker, Link person etc.

Submitted by: ____________________**(signature with seal)**

Name: ____________________

Designation: ____________________

Annexure 2

Muster roll for the intensified immunization training of front-line health workers

State: ______________________ **District:** __________________________

Block / Urban Planning Unit: ____

Sr. No.	Name of participant	Designation [#] (Encircle)	Contact number	Signature
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
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		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		
		LHV / HS / ANM / ASHA / AWW / Others		

[#] Others includes HW(Male), Urban health worker, Link person etc.

Submitted by: ______________________________**(signature with seal)**

Name: ____

Designation: _____________________________________

Annexure 3

Block reporting format for immunization training of front-line health workers

(To be submitted weekly by the BMO to the DIO)

Reporting Week: From: ____________ To: ____________

State: ____________ **District:** ____________ **Block/ Urban Planning Unit:** ____________

Sr. No.	Category of Training* (Encircle)	Date of training session	Number of participants										Name of facilitator	Facilitator trained in TOT (Encircle)	Info-kits distributed (Encircle)
			LHV/ HS		ANM		ASHA		AWW		Others#				
			Expected	Attended	Expected	Attended	Expected	Attended	Expected	Attended	Expected	Attended			
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
	1 / 2													Yes / No	Yes / No
Total															

* 1=LHV/HS/ ANM; 2=ASHA/ AWW/ Others # Others includes HW(Male), Urban health worker, Link person etc.

Attach copies of Muster Roll (List of participants with designation, place of work, contact numbers and signatures)

Submitted by: ____________________ **(signature with seal)**

Name: ____________________

Designation: ____________________

UNIT-12

High risk populations and Urban areas

Learning objectives

- *List steps to include high risk areas and populations in the RI microplans*
- *Explain the challenges and steps to provide RI services in urban areas*

Key Contents

High risk areas/populations	247
Provision of services	248
Steps to be followed by block/urban area MOs and DIOs	249
Urban services	250
Challenges to providing immunization in urban areas	251

High-risk areas and urban services

12

High risk areas/populations

HRAs are special sites/areas which may be one or more of the following types of areas:

- Hard-to-reach areas
- Unserved or underserved areas or areas with shortage of health workers
- Urban areas, especially slums
- Migratory populations including temporary harvesters, brick kiln workers and construction labourers in large construction sites
- Security compromised areas.

The polio programme has identified population groups/areas that often miss routine and supplementary immunization and pose a risk for polio and other VPDs. HRAs are categorized as migratory and non-migratory (settled). (Other high risk populations could include those living in prisons, brothels and redlight areas)

Migratory HRAs

Migratory HRAs have been characterized as follows:

- ***Slums with migration:*** These are settlements in urban/periurban areas, or slums situated close to industrial areas including mining/stone-crushing sites or agricultural fields. These slums are typically found listed as such with urban development or district authorities. These areas are densely populated with substandard housing, which may be pucca or kaccha (jhuggies) and invariably have poor sanitation. Some of these areas are unauthorized and/or are not recognized by urban development authorities. The socioeconomic status of the residents in these areas is low.
- ***Nomads:*** Populations such as Mangteys, Kanjars, Fakirs, Natts, Banjaras, Shahs, Shahbalis, Albis, GadhiaLuhars, Ghumantus, etc. often move from place to place for livelihood, usually setting up "dera" wherever they stop. They are normally found in between or at the end of big colonies, railway stations, along the rail tracks, open fields, market places and in urban/periurban slums.

- ***Brick kilns:*** Migrant labour camping in brick kilns and the "pather" fields where raw bricks are prepared.
- ***Construction sites:*** Migrant families live in jhuggies or brick sheds in and around the under-construction buildings. The number of families and children present in these sites varies according to the size of the construction site.
- ***Others:*** These are fishermen villages, riverine areas with shifting populations, etc.

Non-migratory HRAs

These are areas with settled population with no migration and poor immunization coverage. These include hard-to-reach areas and misinformed communities that refuse vaccination due to misplaced beliefs.

Hard to reach areas

Accessibility compromised areas i.e. due to geographical / topographical reasons and in areas where security is a concern poses a different challenge to delivering RI or any other services.

Provision of services

Despite these challenges frontline workers and health staff are committed to providing services even in such areas. Therefore it is important for RI microplanning to be flexible and respond specifically to local situations and needs.

As MO you can review situations and in consultation with the district be innovative to overcome some of these obstacles.

For areas with multiple pockets of nomads or construction sites:

- Ensure identification of each area or pocket
- Identify a key person in each
- Explore use of mobile session for such areas

For hilly regions:

- Due to the vertical spread and terrain microplanning including maps should be made to reflect the ground realities
- Mobilization of beneficiaries will benefit from innovation. E.g. using available telecommunication /sending messages through school children returning home or through other agencies
- The use of alternate vaccine delivery options which may include pack animals or other modes of transport

- ANMs / health workers may have to stay overnight is some areas this will require extra vaccine carriers with extra ice packs to ensure maintenance of cold chain
- Immunization waste management – all waste will have to return to the centre for further management.

Steps to be followed by block/urban area MOs

1. Update the available list of all HRAs in the block/urban area every 3 months.
2. HRAs that are not included in the microplan should be immediately added, with appropriate revisions.
3. Review monitoring and coverage reports to identify issues in provision of immunization services with special emphasis on HRAs to include:
   a. Planned sessions not held
   b. Areas with low coverage
   c. Sessions with poor mobilization
   d. Status of due-list updating, especially for migrants and newborns
4. Revise session sites and timings, wherever required, in consultation with the ANM, ASHA, LW,AWW and community members.
5. Followup the progress regularly.

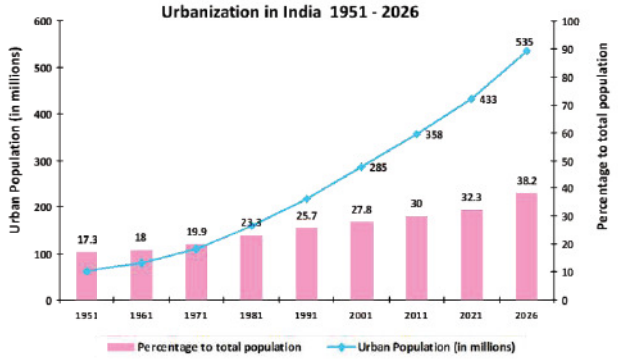
Steps to be followed by DIO

1. Review the maps and microplans from each block to check that all the HRAs are included in the ANM work-plan;
2. Review monitoring reports to identify issues;
3. Prioritize block/s with large number of HRAs;
4. Facilitate block level review and revision in priority blocks.

Any area with a risk for disease transmission or outbreak can be included as an HRA by MO.

Urban services

Virtually all population growth over the next 30 years will be in urban areas. By 2030, six out of every 10 people will be city dwellers, rising to seven out of 10 people by 2050. The trend for the past 50 years is for cities to grow horizontally in the form of urban sprawls, whether as suburbs or as peri-urban expansion.



India has been urbanizing rapidly in recent decades. It is estimated that the urban population will nearly double to reach 534 million by 2026.

Urbanization and its health impacts are not just an issue for with over 10 million residents. In fact, much of the urban population growth will occur in small and mid-sized cities. While large cities of developing countries will account for 20% of the increase in the world's population between 2000 and 2015, small and mid-size cities (less than 5 million) will account for 45% of this increase.

India is on the brink of an urban revolution with nearly 30% (about 300 million people) of the total population living in towns and cities. As per the United Nations projections, if urbanization continues at the present rate, 46% (about 500 million people) of the total population will be concentrated in urban regions of India by 2030. Migration is a major driving force for this rise in urban population. This exponential growth in urban population is leading to many problems such as increasing slums, decrease in standard of living in urban areas and contributes to environmental damage.

The definition of urban area as per the 2011 Census is as follows:

(a) All statutory places with a municipality, corporation, cantonment board or notified town area committee, etc.

(b) A place satisfying the following three criteria simultaneously:

i) a minimum population of 5000;

ii) at least 75% of the male working population engaged in non-agricultural pursuits;

iii) a density of population of at least 400 per sq km (1000 per sq mile).

An urban agglomeration is a continuous urban spread constituting of a town and its adjoining urban outgrowths, or two or more physically contiguous towns together and any adjoining urban outgrowths of such towns.

Characteristics of urban areas

- Ever expanding borders and peri-urban areas
- HRAs - higher number of construction and nomadic sites
- Manpower shortages.
- Large volume of transit / migrant population
- Unrecognized slums

Challenges to providing immunization in urban areas

Providing immunization services in urban areas have the following challenges:

1. Area demarcation
2. Accessibility
3. Inadequate infrastructure to support RI sessions
4. Multiple agencies / bodies for coordination

1. Area demarcation

Most of the urban areas in cities and towns are defined clearly with local urban bodies and infrastructure. However, the demarcation of areas among health workers is a challenge due to either overlapping administrative areas or expanding areas.

Area demarcation in urban areas is an investment that will be beneficial to all and is worth the effort. Except for the periphery or peri-urban parts, for the rest of the area it will be a onetime activity to develop maps and demarcate areas.

Source of maps in urban areas:

- Local urban bodies such as municipality / corporation / Dept. of urban development (see Unit 3, Fig 3.7)
- Simple hand drawn maps made by health workers (see Unit 3 Fig 3.8)
- Using google maps (Fig 12.3 and 12.4)
- Upgrading existing maps to clearly demarcate (Fig 12.2)

To clear up issues of area demarcation:

- Have copies of maps of each urban SC area prepared / copies made if already available
- Call for an ANM meeting and/or coordinated meeting with ICDS (if available)
- Bring out discussion on areas of confusion
- Clarify and if needed take decisions based on ease of access / rationality and finalize
- Plan for field verifications where boundaries are not well defined.

If there is an existing AWW/ASHA/link worker network, areas can be demarcated on the same lines. This makes it simpler to identify areas. Once this is done, ANM areas can be superimposed on the maps.

Fig 12.2 Urban PHC area polio map showing landmarks and upgraded to include migrant population mapping

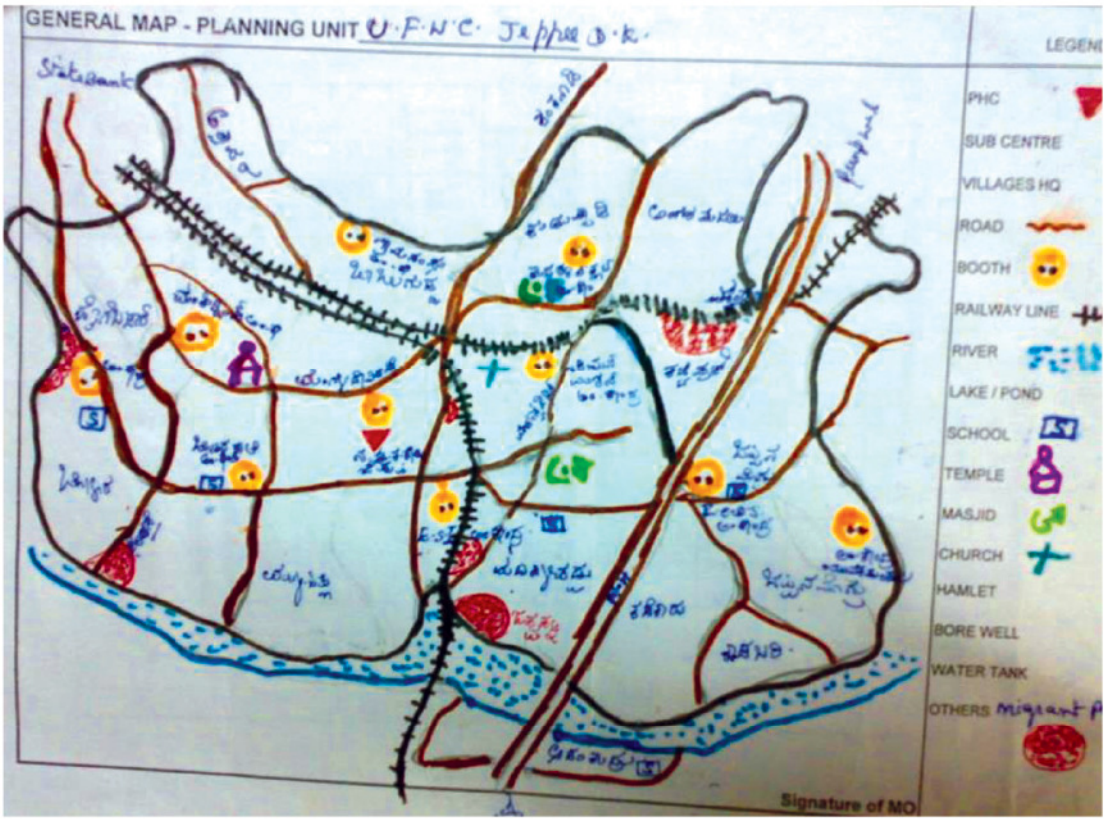
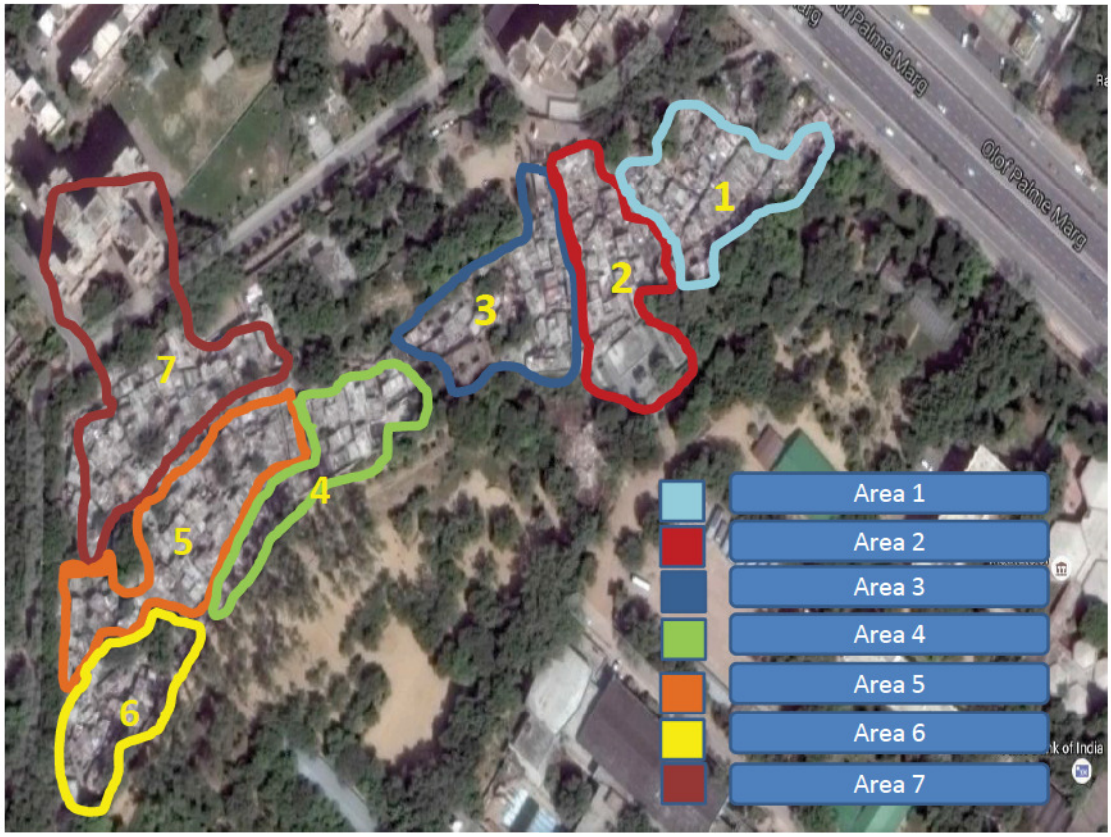


Fig 12.3 Urban PHC area map – screen grab from google maps

Fig 12.4 Urban SC area map – screen grab from google maps – with areas demarcated for ASHA/LW



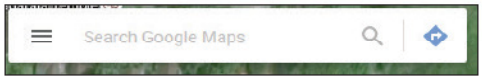
Steps to use google maps

Using google maps may seem to be very complicated but for the purpose of getting a birds eye view of your area it is as simple as viewing a photograph on your computer.

Step 1 – go to www.googlemaps.com (generally the map identifies your IP address and shows the area you are located automatically)

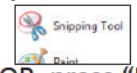
Step 2 – at the bottom left of the screen click on the "earth" 

square so this will show you a satellite image rather than line map.

Step 3 –at the top left of the screen in the 

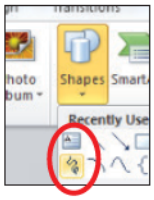
"search google maps"enter the name of your area.

Step 4 – using the scroll button  on the mouse or the + and – icons  on the map zoom into any area on the map.

Step 5 – once you have identified the area you wish to use as a map, either use the "snipping tool" 

from "ACCESSORIES folder" from Windows Menu to cut out the area you need OR press "PrtScn"  to get an screen image of the map. (For Mac computers use Command-control-shift-3)

Step 6 – paste the image on a PowerPoint slide or in a word document.



Step 7 – using the "insert shapes" option you can draw around an area using the "scribble" option (see Fig 12.4) OR take a print out and draw directly on the print out to demarcate areas.

Step 8 – save the file with area name and take a print out of the final map.

2. Accessibility

One of the challenges facing urban HWs is the large number of high-rise buildings, industrial areas and apartment complexes. Other challenges include narrow lanes, distance from local public transportation, high density and also access to flats and families living in them. The local solutions to providing services include:

- Using three or two wheelers to access narrow lanes;
- Involvement of industries – individually or through their organizations;
- Involvement of the apartment associations in planning and support to the HWs during visits;
- Involvement of local municipalities or corporations to issue instructions to all apartments or other associations in an area;
- Seeking support from local key influencers and community leaders;
- Support from local civil service organizations – Rotary, Lions, professional bodies, etc.

The MO with support from the local workers can discuss and develop locally specific solutions in such areas.

3. Infrastructure for providing RI services

Urban immunization services to be operationalized in the following way:

1. **"Same day, Same site, Same time" provision of services:** This should include:
    - All sites including Anganwadi centres, dispensaries, clinics and maternity homes in the public sector;
    - All NGOs engaged in providing health care in urban areas;
    - Any private institution /practitioner willing to support RI services.

2. **Urban outreach:** Expand the network of urban service provision points from the health facility:
    - 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 Unit 3) for the expanded network of urban outreach;
    - Plan location of sites, frequency and timing of service to suit the local population;
    - Establish contact with the local leader and obtain support;
    - 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
3. **Communication:** Communication through ICDS workers, LWs,HWs, NGOs active in the area, print media, television and radio about the following:
    - The timing of local immunization services;
    - Local service delivery points;
    - The vaccines and schedule of immunization;
    - The benefits of immunization.

4. Multiple agencies / bodies for coordination

In addition to the Municipalities and Corporations there are many other departments that can be approached for support. E.g. Department of Telecommunications can be approached for help to send SMSs through government mobile network or from private sector under Corporate Social Responsibility / local FM radio stations to be involved or conduct special programs for immunization or Department of Transport can be approached to display banners or posters on government vehicles or to facilitate support from private transport companies.

Urban areas have the advantage of many non-governmental organisations working in the peripheries or in slums. These organizations can be approached for support or for active involvement in some areas where they have a strong presence.

Educational institutions can be approached directly or through the Department of Education for support. Nursing colleges can be approached for support during campaigns or in areas where there are vacancies in the urban health infrastructure. Involving multiple organisations requires careful planning and inter-sectoral coordination, consult with CMO/ DHO and DIO for guidance and support.

Refer to frame work for implementation of National Urban Health Mission for urban specific guidelines.

Notes:

UNIT-13

Financial planning in Immunization

Learning objectives

- *Understanding the process flow in Programme Implementation Plan (PIP) preparation under National Health Mission*
- *Overview of the Financial Management Report (FMR) codes and budget utility in immunization*

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