UNIT-8

Supervision and monitoring
Learning objectives

- To describe the importance of supervision and monitoring
- To list the steps for conducting supportive supervision
- To explain the steps for conducting effective review meetings
- To list common issues observed during monitoring and supervision of the immunization programme
- To analyse the data from routine and monitoring reports to develop an action plan for improving immunization coverage
- To describe various tracking tools available for tracking “missed children”.

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Supervision and monitoring

Supportive supervision is a process of guiding and assisting staff to continuously improve their own work performance. It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve the knowledge and skills of health staff. Supervision encourages open, two-way communication and builds team approaches that facilitate problem solving.

Monitoring involves regular collection and analysis of data on various aspects of programme activities. Monitoring can be done through desk review of reports, providing feedback on phone or by e-mail/letter during the review meetings as well as during supervisory visits.

Fig. 8.1. Supervision matrix

Supervision must involve interaction with staff and usually also has an element of monitoring. During the supervisory visit, the supervisor can monitor the quality of service delivery, find out the reasons for unimmunized and under-immunized children and plan interventions to reach and sustain them. It can be done at session site and house-to-house (community) using the monitoring formats at the end of this Unit.
**Steps for conducting supportive supervision**

**Step 1: Prepare for effective supportive supervision**

Ensure the following three main *Rights* as follows:

- **Right supervisors**
  
  Identify and prepare a pool from the available staff, i.e. MOs (including AYUSH), health supervisors, ICDS supervisors, block programme managers, immunization field volunteers, etc. Train them on the immunization schedule, the process and the information to be collected.

- **Right tools**
  
  Use monitoring formats and SOPs for session, house-to-house and block (for recording observations), also use training materials and job aids (to update skills of HWs during the visits).

- **Right resources**
  
  Ensure that sufficient mobility and time is allocated for the visits and followup.

**Step 2: Plan regular supervisory visits**

Plan regular supervisory visits as per the microplan, considering three *Ws*:

- **Where** to conduct visits (priority areas)
- **When** to conduct visits (on immunization session days after informing the HWs)
- **What** to do during visits (review data and previous supervision and monitoring reports)

**Prioritization of areas**

An updated RI microplan is a prerequisite for monitoring, as it helps to prioritize the areas for monitoring visits. The priority should be to visit:

- listed HRAs in the microplan
- areas missed in the microplans
- villages with vacant SCs
- peri-urban underserved areas
- ANM with large catchment population
- area with reported measles outbreak, wild polio virus (WPV) or vaccine derived polio virus (VDPV)
- migrant and mobile populations
- areas with low RI coverage/resistance.
Step 3: Conduct supportive supervision visits

Session site visit

After deciding the area to be visited, plan to visit the nearest session site catering to that area. Visit the session site on the scheduled day and time and collect information using the session monitoring format. If the session is held, do the following:

- observe the ongoing session, e.g. who is mobilizing the children, how the HW is vaccinating each child, messages provided by HWs, etc.
- interview the HWs for additional information, e.g. supervisor visits made, Measles/MR2 dose, RCH register, ASHA incentives, etc.
- interview any three caregivers to know who has mobilized them.

House-to-house visit

- If the session is not being held, (find out the reason for the same) proceed for house-to-house monitoring. House-to-house monitoring helps in rapid assessment of RI coverage in the community. Visit 10 households with children aged 0–35 months (<3 years) and collect data on the house-to-house monitoring format through RI/MCP card and interviews of caregivers.

Before leaving the field

- Provide feedback to the health staff concerned. Start with positive feedback followed by the specific weaknesses
- Identify problems, discuss the causes of the problem with health staff and plan the solutions
- When required, provide on the job training as an immediate solution. First explain and demonstrate the skill, then allow the HWs to practice the skill, providing feedback till they learn.

Step 4: Followup

After the supervisory visit, you should:

- followup on the agreed actions in the implementation plan;
- discuss with other block officials (MOIC, etc.) the issues of RI implementation in the block, if related to their department – e.g. departments of education, women and child development (ICDS), power supply, etc.
- provide a feedback to higher levels for support in problem solving;
- conduct follow-up visits to see if the recommendations are being implemented and if there is improvement in the performance of the HWs.
- Record results of supervision and prepare the report.
Common issues observed during monitoring and supervision of the immunization programme

The following issues have been identified during regular monitoring in the field. This is not an all inclusive list but helps to categorize issues to enable corrective actions.

Human resource issues
- Vacant SCs
- Inadequate hiring of alternate vaccinators for vacant urban and rural areas
- Irrational distribution of the workload/areas among the HWs within a block
- Absenteeism of HWs
- Lack of designated cold chain handlers at cold chain points
- Lack of regular capacity building of knowledge and skills of health staff.

Microplanning issues
- Microplan not prepared or incomplete with only roster of the HW
- Missed areas and population groups, e.g. migratory and mobile population, urban slums, hamlets and geographically distant population not included
- Microplans not based on head count survey
- Map of the SC and PHC not prepared/displayed
- Area demarcation of SC with two ANMs is not done to clarify their individual roles
- Microplans are not reviewed at regular intervals.

Operational issues
- List of due beneficiaries for the sessions is not prepared
- All the planned sessions are not held by ANM due to leave, post being vacant, ANM not going to the site
- Poor attendance at outreach sessions due to poor mobilization by ASHA and AWW
- Late start of session and early closing of session site
- Non-availability of all vaccines and logistics at the session site
- Incorrect route/site/technique used for vaccine administration
- Date and time not recorded on reconstituted vaccine vials
- 4 key messages not conveyed to the beneficiary/caregiver
- Coverage monitoring chart and tracking bags not available at PHC or SC
Cold chain and logistics management issues
- No dedicated trained person in charge of cold chain at PHC level
- Job aids for cold chain maintenance not displayed at cold chain point
- Guidelines for correct storage of vaccines and diluents in ILR not followed
- Temperature not recorded twice a day; recording by cold chain handler not monitored
- Contingency plan for emergencies not prepared/followed
- Preventive maintenance of cold chain equipment not in place
- Presence of snake anti venom/other drugs/eatables in ILR along with vaccines
- Stock registers not updated and supervised for record of issue and balance of vaccines and other logistics
- Timely indenting of vaccines and logistics not done resulting in stock-outs being reported.

Recording and reporting system issues
- RCH/MCTS register not updated regularly and not used in preparation of beneficiary due list.
- Careless recording in immunization/MCP card; counterfoils not maintained
- Due list-cum-tally sheets not used for session-wise recording
- No system for identification and tracking of dropouts and left outs
- Monthly reports – incomplete and not analyzed for feedback and action
- AEFI and VPD cases not being reported or being underreported
- Block AEFI registers not being used.

Injection safety and waste disposal issues
- Hub cutter not available/not being used immediately after vaccination/reconstitution
- Red and black bags not available/not being used
- Disinfection of immunization waste not practiced before disposal
- Sharps pits for needles not constructed/functional at PHCs.

Monitoring and supervision issues
- Supervisory visits not planned/conducted by health and ICDS supervisors in priority areas
- Review meetings not used for providing feedback of monitoring and use of data for action.
Issues in community involvement and communication

- Weak coordination with other related agencies and sectors such as private and NGO sectors
- Lack of information, education and communication (IEC) and social mobilization activities contributing to poor utilization of services
- Four key messages not being given to beneficiaries at sessions.

Steps for conducting effective RI review meetings

Meetings are regular event at a PHC, use each meeting as an opportunity to identify, solve issues with service delivery.

Prepare for the meeting

- Determine the objectives of the meeting based on review of the minutes of previous meetings, monitoring reports and any new guidelines/topics to be discussed
- Prepare the agenda including objectives, list of topics to be covered, name of the facilitator for each topic and the time duration
- Assign logistic arrangements to the members of the team
- Assign talks on specific technical topics to concerned supervisors and colleagues
- Inform the date, time and place of the meeting to all participants.

Conduct the meeting

- Start the meeting on time
- Enquire if participants are comfortable. Make changes if needed.
- Follow the agenda closely during the meeting to ensure that set objectives are met
- Ensure that the meeting is focused and participatory
- Keep listening and summarizing the key points raised at regular intervals
- Ensure that minutes are taken with actionable points and timelines
- Summarize the action points, including persons responsible and deadlines
- Agree upon date of next meeting
- Thank participants.

Followup

- Forward unresolved issues to the district level for necessary action
- Examine the meeting process. Assess and make a plan to improve the next meeting
- Followup in writing to document key action points.

A sample agenda for a PHC review meeting of ANMs is given in Table 8.1.
Table 8.1: Sample agenda for PHC review meeting of ANMs

<table>
<thead>
<tr>
<th>Time</th>
<th>Activities</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00–10:15</td>
<td>Welcome &amp; objectives of the meeting</td>
<td>MOIC</td>
</tr>
<tr>
<td>10:15–11:15</td>
<td>Feedback on supervisory visits and monitoring data</td>
<td>MO/health supervisor/ partner</td>
</tr>
<tr>
<td>11:15–11:45</td>
<td>Feedback on data analysis from the monthly reports for left-outs and dropouts</td>
<td>health supervisor</td>
</tr>
<tr>
<td>11:45–12:30</td>
<td>Review of microplans, immunization records/reports, any other issues such as ASHA/AWWs involvement in mobilization of beneficiaries</td>
<td>MOIC</td>
</tr>
<tr>
<td>12:30 –13:00</td>
<td>Action plan to improve coverage and track missed children</td>
<td>MOIC/health supervisor</td>
</tr>
<tr>
<td>13:00–13:15</td>
<td>Summary and conclusion</td>
<td>MOIC</td>
</tr>
</tbody>
</table>

**Quarterly review meetings**

Under National Health Mission, there is a provision to conducting quarterly review meetings for RI at block level under part C, FMR code c.1.f (refer Unit 13) for ASHAs. As per norms, Rs. 50/ per person as honorarium for ASHA (Travel) and Rs. 25/person at the disposal of MO-IC for meeting expenses (refreshment, stationary and misc. expenses) is available for conducting review meeting four times in a year.

These funds should be utilized for improved planning and supervision of front line health workers for Routine Immunization activities.

**Tracking tools to track ‘dropouts’**

Various tracking tools are as follows:

- MCP Card with counterfoil
- Tracking bag
- Immunization/RCH/MCTS Registers
- Name-based list of due beneficiaries (refer SOP RI form 6 - Unit 3)

**Mother and Child Protection (MCP) card with counterfoil**

The MCP Card is a tool for families to learn, understand and follow positive practices for achieving good health of pregnant women, young mothers and children.

The card gives information on the immunization schedule and the doses of Vitamin A to be given to the child during the first five years. Boxes in the chart indicate each type of vaccine, date to be given, date when it was given and age.
Details that would be available from MCP Card are:

- the date in the pink box when the child is expected to come for next immunization
- the date in the white box when the child came for immunization.

**How to use the card**

- During the first visit, fill the information on the cover page on “Family Identification and Birth Record”.
- Record the date, month and year of all entries clearly.
- Explain the section on immunization by explaining which vaccines have been given and which vaccines are due, with dates.
- Do not leave any cells or columns blank.
- After filling up all the columns, retain the smaller portion of the card (counterfoil).
- Give the rest of the filled-in card to the parent of the child after immunization and ask her to bring the same card during her subsequent visits to the health centre.
- Advise families to keep the card in a safe place to prevent it from damage.
- Advise families to bring the card along when they visit the Anganwadi Centre (AWC), SC, health centre, private doctor or a hospital.
- At the end of each session, the counterfoils should be placed in the appropriate pocket of the tracking bag.
- Each month, look at the counterfoils in the tracking bag and make sure those children come for immunization. If they miss the session, ask the ASHA/AWW to follow up with those families and ensure that they attend the next session.
Fig 8.2 – Infant RI card and counterfoil

Tracking bag

Keeping counterfoils in tracking bag helps in:

- preparing a session-wise name-based list of due beneficiaries for sharing with the ASHA/AWW/mobilizer
- estimating the vaccine requirement for the next session
- tracking the dropouts
- providing information, if the beneficiary/parent has lost the immunization card.
The counterfoils need to be filed separately for each session site. A cloth tracking bag with 15 pockets is a simple, easy to use tool for filing the counterfoils (Fig. 8.3 and 8.4). The first 12 pockets indicate each of the 12 months of the year. The thirteenth pocket is for those who left/died during the period, the fourteenth pocket is for fully immunized children and the fifteenth pocket is to store blank MCP cards.

Once a beneficiary is immunized, the counterfoil would be placed in the month (pocket) due for the next dose (see Fig 8.4). For example, if a child comes for Penta 1 in January, Penta 2 is due in February. Update and place the counterfoil in the February pocket.

When the Penta 2 dose is given in February, update the counterfoil and move to the pocket for March. When the Penta 3 dose is given in March, then update and place the counterfoil in the September/October pocket since the child has to return for measles/MR vaccine.

- If some cards are left in the pocket at the end of the month, it indicates that the beneficiaries are the dropouts.
- Move these cards to the next month’s pocket and track them.

Fig 8.4 How to use tracking bag
In case no tracking bag is available, counterfoils for each month can be separately tied with different rubber bands and labelled. File counterfoils for each session site separately and do not forget to carry them to the session.

**Immunization/RCH/MCTS Registers**

Immunization / RCH / MCTS registers help to record and track each pregnancy and immunization. It should be:

- updated to include new pregnancies and births from the records of AWWs and ASHAs before each immunization session;
- updated after each session on the basis of counterfoils filled during the session;
- if the beneficiary is from outside the catchment area, the HW should issue a new card and give appropriate vaccination. Record should be entered in the non-resident column of the register;
- if the beneficiary receives vaccination from a private practitioner, the HW should record the same in the MCH register and the immunization card and write “P” after the date.

**Conducting an effective RI session**

For an RI session to be effective, there are some points that need to be addressed. These are enlisted below:

- Appropriateness of location
- Setting up the site for safe injections:
  - Basic furnishings and spacing
  - IEC display
- Advance information to community
- Information on arrival.

**Field Tip: “SAME DAY, SAME SITE, SAME TIME”**

Ensuring the RI session is conducted on the same day, at the same site and at the same time builds community confidence and faith in the system and health worker.
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Appropriateness of location

The RI session site should be:

- easily accessible and identifiable – using the IEC posters/banners at a visible point;
- located in the same place each and every time;
- in a clean area, out of the sun and rain – avoid open-air sites;
- having space either within the premises or near a sheltered/shaded area where those needing vaccination can wait;
- large enough to provide space to have separate stations for—registration and assessment; immunization and record keeping; and screening/education on other health issues;
- quiet enough for HWs to be able to explain what they are doing and to give advice.

All these parameters may not be possible at all places. However, in many instances it is possible with community support to ensure the best resources in the available circumstances. The MOs must visit all the RI session sites over the course of a few months and ascertain their appropriateness.

All communities are very proactive and supportive towards immunization services if they are involved in the planning process. It is necessary at times to reach out to the community through key influencers and local leaders in areas where ground realities make it difficult to identify or locate the site.

An ideal set-up for an RI session is shown in Fig. 8.5.

Setting up the site

Displaying IEC material, i.e. either the poster or banner or even both outside the session site informs the community of the arrival of the ANM and that the RI session site is now functional. The IEC display should be visible from the approach road and clearly identify the session site. The ANM should spend time after arriving at the session site to arrange the site to make it as convenient as possible for her and her supporting ASHA/AWW and also for the community that comes for services.

Sourcing furniture or requesting support from the community reflects the rapport of HWs and community involvement. In places where there is less support, it is necessary to address the issue with the community leaders at the earliest. Though this may seem an unimportant or minor issue, lack of community involvement is a factor that has a negative impact on RI coverage and mobilization of beneficiaries. A well setup RI session helps to build community confidence and also contributes to providing a quality experience for the HWs and beneficiaries.
Advance information to the community

Providing advance information of the upcoming RI session in an area has many advantages. Various examples exist across the country, e.g. issuing invitation cards to beneficiaries, house-to-house visits by ASHA/AWW workers 2 days before the session, using mothers’ meetings to announce the upcoming date and the beneficiaries. These are some of the innovative ways of informing beneficiaries. Explore what could work in your area.

Information on arrival of ANM

While the ASHA/AWW/mobilizer will visit the beneficiaries to come for immunization, word of the arrival of the ANM can also be spread through using any public address system at a religious or community centre. With support from local leaders, information can also be passed through students or local shopkeepers. The intention is to announce the starting of the session and any other local methodologies should be explored and encouraged.
The four key messages the HW should give to the caregiver are:

**Four key messages for caregivers**

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

Using RI monitoring formats

Monitoring in routine immunization is an essential tool for a medical officer. It provides an opportunity to:

- observe service delivery and practices
- identify issues and provide solutions at field level
- identify training needs of staff
- interact directly with the community
- interact and motivate frontline health care workers at field level
- build confidence in health workers and community
- increase understanding of the RI delivery mechanism

Two types of formats are in use – RI session site and House to house monitoring formats.

1. The RI session format focuses on the following: Microplanning, session due list & its quality, safe injection practices, vaccine availability at session site, implementation of open vial policy, logistics, IEC and ASHA incentives.

2. The house to house format focuses on collecting information from at least 10 children below the age of 35 months in an area. Information on the child’s vaccination status including the dates of administration is to be collected, the source of information being the MCP card. However in the absence of the card, parent recall by identifying the sites of injection may be utilized. The rear of the format has a ready reckoner to easily identify if a child has received due vaccine as per age. When a child is found unimmunized or partially immunized information on the reason should also be collected.
### Session Site Monitoring Format for Routine Immunization

**Enquire appropriate options. For "*" marked questions, multiple responses may be applicable.**

<table>
<thead>
<tr>
<th>State/UT:</th>
<th>District:</th>
<th>Name of Block / Urban:</th>
<th>Setting: Rural</th>
<th>Urban Date:</th>
<th>_ / _ / _</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning Unit:</td>
<td>Village/Mohalla/Ward:</td>
<td>Name of session site:</td>
<td>At least 1 session was held in last 3 months:</td>
<td>Y / N / Unknown</td>
<td></td>
</tr>
<tr>
<td>Subcenter/Urban Health Post:</td>
<td>Name of ANM:</td>
<td>Monitoring time:</td>
<td>Designation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Monitor:</td>
<td>Organization: WHO / Govt / UNICEF / OPEF / UND / OX / Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Session Details

1. **Reason for monitoring**
   - a) Polio High Risk Area/Group: (PRA/RSG)
   - b) Measles outbreak in last 1 year
   - c) Other VPD outbreak in last 1 year
   - d) Session planned in a vacant session center (select one option)
   - e) Others

2. **If polio HRA type of HRA/RSG:**
   - a) Slum with migration
   - b) Nomads
   - c) Brick kiln
   - d) Construction site
   - e) Other non-migratory high-risk area
   - f) Other non-migratory high-risk area

3. **Location of the session site per micronet:**
   - a) District Hospital
   - b) CHC
   - c) PHC
   - d) UPCHC
   - e) Sub-centre
   - f) Urban Health Post
   - g) ICDS Centre
   - h) HRC site (fixed)
   - i) HRC site (by mobile team)
   - j) Others

4. **Is the session being held?**
   - Yes / No
   - A) Early closure
   - B) ANM absent
   - C) Vaccine logistics not available
   - D) Others

   If session is not held, skip Q5 to Q34.

5. **Whether vaccine was delivered?**
   - a) Alternate Vaccine Delivery
   - b) ANM
   - c) Others

6. **Mobilizers per micronet:**
   - a) ASHA
   - b) AWIN
   - c) Link workers
   - d) CMC
   - e) Others

7. **Mobilizers working today:**
   - a) ASHA
   - b) AWIN
   - c) Link workers
   - d) CMC
   - e) Others

8. **Headcount survey conducted for children under 2 years and pregnant women for session catchment area within last 6 months:**
   - If conducted, is the list of beneficiaries available?
   - Yes / No: In process / NA (not conducted)

9. **DPC list of beneficiaries for this session is available with:**
   - a) ANM
   - b) ASHA
   - c) AWIN
   - d) Other mobilizer
   - e) Not available with anyone of them

10. **Beneficiaries included in due list (quantity & updation):**
    - New born for this session
    - Beneficiaries missed in last session
    - Beneficiaries due for next dose
    - Recent pregnant women

#### Vaccines

- **BCG**
  - Yes / No
  - Pentavalent
  - Yes / No
  - TT
  - Yes / No

- **OPV**
  - Yes / No
  - DPT
  - Yes / No
  - TT
  - Yes / No

- **bOPV**
  - Yes / No
  - Measles/MR
  - Yes / No
  - Pneumococcal (PCV)
  - Yes / No

- **Rotavirus (Rv)**
  - Yes / No: Not applicable
  - Diluent Measles MR
  - Yes / No

11. **Children policy:**
    - a) OPV
    - b) Pentavalent
    - c) DPT
    - d) PPV
    - f) TT
    - e) None

12. **Reconstituted vac or BCG, Measles JR & partially used vaccine supplied to the session site?**
    - Yes / No
    - a) BCG
    - b) Measles
    - c) JE
    - d) DPT
    - e) None

13. **Logistics, other than BCG, Measles & DPT & partially used vaccine supplied to the session site?**
    - a) AD (0.1 ml) Syringes
    - Adequate / Inadequate / Not available
    - Vitamin A: Solution
    - Available / Not available
    - Ameox: Tablet / Syrup
    - Available / Not available
    - Vitamin A: Syringe
    - Available / Not available
    - Zirn: Tablet / Syrup
    - Available / Not available

14. **Any leakage/stock issues in syringes reported by ANM at session?**
    - Yes / No
    - If Yes, enquire a) AD (0.1 ml) Syringes
    - b) AD (0.5 ml) Syringes
    - c) Sml Reconstitution Syringe
    - d) Paracetamol Tab / Syrup
    - e) tracking bag

15. **Blank R: MCP card available to provide to caregiver/ beneficiaries?**
    - Yes / No
    - If No, enquire a) MCP card
    - b) Blank R/MCP card

16. **Does the MRP/MCP card have counterfoil for ANMs for tracking missed doses?**
    - Yes / No
    - a) Counterfoil
    - b) Blank R
    - c) MCP card

17. **Enquire new vaccines included in blank R/MCP card?**
    - a) Pentavalent
    - b) OPV
    - c) Rotavirus
    - d) MR
    - f) PCV

18. **Status of hub cutter availability?**
    - a) Functional
    - b) Non-functional
    - c) Hub cutter not available
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#### Four key messages to all caregivers:

- **ANM delivering four key messages to all caregivers:**
  - Message 1: What vaccine was given and what disease it prevents?
  - Message 2: What are the minor side effects and how to deal with them?
  - Message 3: When to come for the next visit?
  - Message 4: Keep immunization card safe and bring it along in the next visit.

#### Interview three caregivers separately to assess who mobilized them to the session site (Select ‘NA’ if monitor could not interview):

<table>
<thead>
<tr>
<th>Caregiver - 1</th>
<th>Caregiver - 2</th>
<th>Caregiver - 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASHA / AWW / ANM / CMC / Link worker / Others / None / NA</td>
<td>ASHA / AWW / ANM / CMC / Link worker / Others / None / NA</td>
<td>ASHA / AWW / ANM / CMC / Link worker / Others / None / NA</td>
</tr>
</tbody>
</table>

#### Any display of RI specific IEC material at session site?

- a) No display
- b) Displayed with RI logo: Be Wise, Get your child Fully Immunized
- c) Some other logo/flagline on immunization

#### Any other important observations:

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### Meet MO in charge to ascertain reasons for monitored session not held. Skip Q-36 and/or 37 as applicable.

<table>
<thead>
<tr>
<th>Why ANM was not available at session site?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) On leave b) Vacation post c) Assigned other work d) Stated late e) Others (specify):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for non-availability of vaccines / logistics?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Not issued b) Not picked up c) Picked up but not delivered d) Others (specify):</td>
</tr>
</tbody>
</table>

### Visit vaccine storage point to assess the following. Encircle “already answered” if Q38-39 answered in another session format under the same vaccine storage point today.

<table>
<thead>
<tr>
<th>Vaccine distribution register available at the PHC / Urban planning unit / Vaccine storage point?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Yes / b) No / c) Already answered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is there a mechanism for segregating partially used vials in ILR as per revised open vial policy (OVP) guidelines?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Yes / b) No / c) Already answered</td>
</tr>
</tbody>
</table>

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### Immunization handbook for Medical Officers

<table>
<thead>
<tr>
<th>Immunization handbook for Medical Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>194</td>
</tr>
</tbody>
</table>

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### Supplementation

- a) Line listing of households (headcount survey) at the beginning of the year and updated after six months @ Rs 100 (maximum)
- b) Preparation of due list of children for immunization to be updated on monthly basis @ Rs 100 every month
- c) Mobilization of children @ Rs 150 / session
- d) Full immunization @ Rs 100/- per child that has received all due doses up to first year
- e) For Complete immunization (CI) @ Rs 50/- per child that has received all due doses up to the second year
- f) Not received for more than a year
- g) Not aware
### House to House Monitoring Format for Routine Immunization

**Unit 8: Supervision and monitoring**

<table>
<thead>
<tr>
<th>Name of Monitor:</th>
<th>Organization: WHO/ Govt UNICEF/ IPE-INF / IPE SIM/NIKE / UNFPA/ Others:</th>
<th>Designation:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td>District:</td>
<td>Name of Block:</td>
<td>Urban area:</td>
<td>Planning Unit:</td>
</tr>
<tr>
<td>Village/Mohalla/Ward:</td>
<td>Sub centre/Urban: Health Point:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reason for monitoring:** 1. Polio HRA 2. Measles Outbreak in last 1 year 3. Other VPA outbreak in last 1 year 4. Area under vaccine sub-centre 5. Other (Low coverage area / non HRA not monitored for >3 months - Follow up) monitoring 6. Polio HRA type 7. Slums with migration 8. Normal site 9. Hard to reach 10. Other migration high risk areas / non migrant (separately populated) high risk areas 11. Other areas: Yes / No / Not applicable

<table>
<thead>
<tr>
<th>Participant of the child: excluding age specific varicella status</th>
<th>Head 1</th>
<th>Head 2</th>
<th>Head 3</th>
<th>Head 4</th>
<th>Head 5</th>
<th>Head 6</th>
<th>Head 7</th>
<th>Head 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the youngest child aged 6 months in the household</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of the mother / father of the selected child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion (Hindu - Moslem / Other)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the child a child of the family?</td>
<td>Yes / No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex of the selected child: Male / Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of delivery: Govt Hospital / Private hospital / Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth (in dd/mm/yyyy format): if not known; write &quot;NA&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age in completed months (Even if Date of Birth is known)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use freshly-received vaccination age appropriate status. If R/V card is available, monitor must write date (the same day) for vaccines received and "No" for missed vaccines. If card is not available, monitor must write "Yes" for received & "No" for missed vaccines. Monitor MUST mention whether data (age, status, Yes / No) align with age-appropriate vaccine. Monitor must write "NA" against vaccine not due for age or not introduced in UP.

<table>
<thead>
<tr>
<th>Heg: 1st birth dose</th>
<th>OPV 0 dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td></td>
</tr>
<tr>
<td>OPV 1</td>
<td></td>
</tr>
<tr>
<td>Rotavirus-1</td>
<td></td>
</tr>
<tr>
<td>IPV (intradermal wherever applicable)</td>
<td></td>
</tr>
<tr>
<td>Pentavalent-1</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B-1</td>
<td></td>
</tr>
<tr>
<td>DPT 1</td>
<td></td>
</tr>
<tr>
<td>OPV 2</td>
<td></td>
</tr>
<tr>
<td>Rotavirus-2</td>
<td></td>
</tr>
<tr>
<td>Pentavalent-2</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B-2</td>
<td></td>
</tr>
<tr>
<td>DPT 2</td>
<td></td>
</tr>
<tr>
<td>OPV 3</td>
<td></td>
</tr>
<tr>
<td>Rotavirus-3</td>
<td></td>
</tr>
<tr>
<td>IPV (intradermal wherever applicable)</td>
<td></td>
</tr>
<tr>
<td>Pentavalent-3</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B-3</td>
<td></td>
</tr>
<tr>
<td>DPT 3</td>
<td></td>
</tr>
<tr>
<td>Measles / MR 1</td>
<td></td>
</tr>
<tr>
<td>(L.2: Refer applicable)</td>
<td></td>
</tr>
<tr>
<td>OPV booster</td>
<td></td>
</tr>
<tr>
<td>DPT booster</td>
<td></td>
</tr>
<tr>
<td>Measles / MR 2nd dose</td>
<td></td>
</tr>
<tr>
<td>(L.2: Refer applicable)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month:</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>6th</th>
<th>7th</th>
<th>8th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>All</td>
<td>Partial</td>
<td>All</td>
<td>Partial</td>
<td>All</td>
<td>Partial</td>
<td>All</td>
<td>Partial</td>
</tr>
<tr>
<td>Data:</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Acceptable reason(s):** why the child missed one / age specific vaccine(s):

1) Not aware of need for vaccination 2) Did not know where to go for vaccination 3) Has no time / no one to take child 4) Concern for loss of work or wages 5) Session inconvenient for time / location / timing waiting time / unaware of missed dose 6) Unhealthy facility 7) Session not held 8) Vaccine was not available 9) Child was away from home 10) Sick child - care giver did not notice vaccination 11) Sick child - HH did not vaccinate 12) Care giver did not give for multiple injections 13) Previously missed a few / all doses / vaccination 14) HH did not give for multiple injections 15) Experienced minor illness / fever / runny nose / cough / other symptoms / hospitalization / disability 16) Fear of AEFI or hearing 17) Adverse media reports 18) Family is resistant 19) Family has no definite reason 20) Others
### Ready reckoner to ascertain age specific due vaccines of a child

(Monitor to assess vaccination status of the child without consoeding reasons for no or delayed vaccination)

<table>
<thead>
<tr>
<th>Age (Completed months)</th>
<th>BCG</th>
<th>OPV</th>
<th>Hep B</th>
<th>&quot;Rotavirus (RVV)&quot;</th>
<th>&quot;IPV&quot;</th>
<th>DPT + Hepatitis B / &quot;Pentavalent&quot;</th>
<th>Measles / MMR</th>
<th>****JE</th>
<th>OPV Booster 1</th>
<th>OPV Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>BCG</td>
<td>OPV-0,6 (up to 15 days)</td>
<td>Birth dose (Within 24 hours)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>1</td>
<td>BCG</td>
<td>OPV-0,6 (up to 15 days)</td>
<td>Birth dose (Within 24 hours)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>BCG</td>
<td>OPV-0,1</td>
<td>Birth dose (Within 24 hours)</td>
<td>RVV-1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>BCG</td>
<td>OPV-0,12</td>
<td>Birth dose (Within 24 hours)</td>
<td>RVV-1,2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4 to 8</td>
<td>BCG</td>
<td>OPV-0,12,3</td>
<td>Birth dose (Within 24 hours)</td>
<td>RVV-1,2,3</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9 to 15</td>
<td>BCG</td>
<td>OPV-0,12,3</td>
<td>Birth dose (Within 24 hours)</td>
<td>RVV-1,2,3</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>16 to 35</td>
<td>BCG</td>
<td>OPV-0,12,3</td>
<td>Birth dose (Within 24 hours)</td>
<td>RVV-1,2,3</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- If the child received the due vaccines, write date (dd/mm/yy) as per immunization card. If date is not known (card not available/date not mentioned in card), but the child has received due vaccine as revealed from the parents/caregiver, write “Yes” and if the child did not receive due vaccine (missed dose), write “No” in the format. If the child is not due for vaccine or vaccine not yet introduced in the district or vaccine phased out, write “NA.”

**If immunization card is not available, interact with parents/caregiver with the simple questionnaires to ascertain vaccines the child has received for his/her age.**

- **BCG:** Enquire whether any vaccination was given into the skin on the left upper arm, which may have formed a pusule after vaccination. BCG is given only up to one year of age and not beyond.
- **Hepatitis B birth dose:** Enquire for intramuscular (IM) injection of any vaccine in the thigh at birth within 24 hours. (Parents may say/direct towards buttock occasionally).
- **OPV-0:** Enquire whether polo drops were given at birth or within 15 days from birth.
- **OPV:** Enquire if 2 drops of polo vaccine were given orally at 1.5 / 2.5 / 3.5 months of age along with injections in the thigh.
- **Rotavirus vaccine:** Enquire if 5 drops of vaccine were administered after giving 2 drops of polo vaccine.
- **IPV:** Enquire if an injection is given in the right thigh along with 3rd dose of OPV when the child aged within 3 months to one year of age OR given in right arm at 1.5 and 3.5 months similar to BCG vaccine.
- **Pentavalent vaccine:** Enquire if the child received one injection in the right arm (left), any time after 5 months repeated at monthly interval two times (total of 3). The child might have developed fever. Pentavalent vaccine is never started after one year of age.
- **Hepatitis B:** 3 doses of Hepatitis B along with DPT are given in left thigh. DPT + Hepatitis is given in a child who has started with DPT series when Pentavalent vaccine was introduced. Hepatitis B is never initiated after one year of age.
- **DPT:** Similar to Hepatitis B. However DPT is a parent injection causing fever, induration similar to DPT containing pentavalent vaccine.
- **Measles/MMR vaccine:** Enquire if any injection was given on the right upper arm after 9 months of age (1st dose) and after 12-24 months of age (2nd dose).
- **JE vaccine:** This vaccine whenever introduced in select endemic districts is given in two doses in left upper arm at the same time as measles/MM vaccine.
- **OPV booster:** Enquire whether 2 polo drops given between after 16 months of age to a child who has already received three doses of OPV.
- **DPT booster-1:** Enquire if IM injection was given in left thigh after 16 months of age. This indicates DPT first booster if the child has already received three doses of DPT or pentavalent vaccine.

*"Rotavirus" vaccine will be given along with OPV at 6, 10 & 14 weeks and will not be given if child has already started with OPV before or is older than 1 year of age.

**"IPV" is never started after 1 year. IPV is given IM at 14 weeks along with OPV/BS, however given in fractional dose (intradermal) in right arm at 6 and 14 weeks along with OPV and 3.

***Pentavalent vaccine will be administered to birth cohort (within 1 year of age) who has not started with DPT & Hepatitis B and will replace primary series of DPT & Hepatitis B.

****JE vaccine is given at 9 -12 months (1st dose) and at 16-24 months of age (2nd dose) in selected endemic districts (list is updated every year).