



# Universal Immunization Programme Review

(25 August to 8 September 2004)

# UTTAR PRADESH

**WRITTEN ON BEHALF OF AGENCIES TAKING PART IN THE UIP REVIEW:**

GOVERNMENT OF INDIA AND THE STATE GOVERNMENTS OF BIHAR, JHARKHAND, MADHYA PRADESH,  
ORISSA, RAJASTHAN AND UTTAR PRADESH.

ALL INDIA INSTITUTE OF MEDICAL SCIENCES  
CARE  
CENTERS FOR DISEASE CONTROL (ATLANTA, USA)  
CHILDREN'S VACCINE PROGRAMME PROGRAMME FOR ALTERNATIVE TECHNOLOGIES IN HEALTH  
INDIAN COUNCIL OF MEDICAL RESEARCH  
SHRISTI (ENVIRONMENTAL)  
UK DEPARTMENT FOR INTERNATIONAL DEVELOPMENT  
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# CONTENTS

1. SUMMARY .....	1
2. BACKGROUND.....	3
3. METHOD .....	4
4. STRENGTHENING ROUTINE IMMUNIZATION.....	5
5. PRIORITY AREAS FOR IMPLEMENTATION OF THE MULTI YEAR PLAN.....	6
ANNEXES	
ANNEX 1: Method used for the UIP review of six states .....	8
ANNEX 2: Team members, itinerary, and persons met.....	9
ANNEX 3: Selected observations.....	12
ANNEX 4: State presentation .....	24
ANNEX 5: Goals and objectives of the 2005-2010 multi-year plan for the UIP .....	29

# GLOSSARY & ACRONYMS

AD	Auto-Disabled syringe
AEFI	Adverse Events Following Immunization
ANM	Auxiliary Nurse Midwife: key health worker delivering UIP and other primary health care
AWW	Anganwadi worker
AWC	Anganwadi centre
BDCS	Border District Cluster Strategy
BCG	Bacille Calmette Guerin; vaccine against tuberculosis
CDC	Centers for Disease Control (Atlanta, USA)
CIP	Coverage Improvement Plan
CSSM	Child Survival Safe Motherhood
CVP PATH	Children's Vaccine Programme – Programme for Alternative Technologies in Health
DFID	UK Department for International Development
DIO	District Immunization Officer
DPT	Diphtheria, Pertussis and Tetanus vaccine
DT	Diphtheria & Tetanus vaccine
EAG	Empowered Action Group of States
EPI	Expanded Programme on Immunization: WHO programme adopted by countries.
EU	European Union
FI	Full immunization or fully immunized
Goi	Government of India
IAP	Indian Academy of Paediatrics
ICC	Interagency Coordination Committee
ICDS	Integrated Child Development Scheme
IEC	Information Education and Communication
ILR	Ice-lined refrigerator: used for storing vaccines.
IMA	Indian Medical Association
IMR	Infant Mortality Rate
INCLIN	Indian National Clinical Epidemiology network
IPC	Inter Personal Communication
ISP	Immunization Strengthening Project (World Bank Supported)
LHV	Lady Health Visitor
MMR	Measles, mumps and rubella vaccine
MNTE	Maternal and Neonatal Tetanus Elimination
MO	Medical Officer
MYP	Multi-year plan. The strategic plan for the UIP covering 2005 to 2010.
NGO	Non Governmental Organization
NIHFW	National Institute of Health and Family Welfare
NNT	Neonatal Tetanus
NPSP	National Polio Surveillance Project
NTAGI	National Technical Advisory Group on Immunization.
OPV	Oral Polio Vaccine
PHC	Primary Health Centre
POL	Petrol, Oil and Lubricants
PPC	Post Partum Centre
PPI	Pulse Polio Immunization
PRI	Panchayati Raj Institute
RCH	Reproductive & Child Health
RED	Reach Every District strategy
SC	Sub-centre (of the PHC)
SITF	State Immunization Taskforce
TT	Tetanus Toxoid vaccine
UIP	Universal Immunization Programme. The Indian National Immunization Programme
UHC	Urban Health Centre
UNICEF	
USAID	

# ACKNOWLEDGEMENTS

This review was only possible with the generous hospitality, guidance and support of the Ministry of Health and Family Welfare, Government of India and the State Governments of Bihar, Jharkhand, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh.

This review was assisted financially and technically by the following organizations:

ALL INDIA INSTITUTE OF MEDICAL SCIENCES,  
CARE,  
CENTERS FOR DISEASE CONTROL (ATLANTA, USA),  
CHILDREN'S VACCINE PROGRAMME PROGRAMME FOR ALTERNATIVE TECHNOLOGIES  
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UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT,  
WORLD HEALTH ORGANIZATION

# 1. SUMMARY

All the infrastructural elements for delivery of routine immunization are in place in Uttar Pradesh.

But, the system is failing to reach most children, largely, because of a lack of:

- 1) political and bureaucratic commitment
- 2) community ownership of the immunization programme
- 3) demand caused by irregular delivery of services and quality issues.

The Government of Uttar Pradesh is urged to consider the tremendous health benefits of immunization for the 5.4 million infants born in this state each year and to make improvement of vaccine coverage a state health priority. After prioritization, gains in coverage will be achieved largely through management, training, and community partnership efforts and will not require large inputs of scarce human or financial resources.



## **THE KEY RECOMMENDATIONS TO STRENGTHEN ROUTINE IMMUNIZATION**

1. Train all field staff (immediately) on current UIP policies, guidelines, and skills - with special emphasis on micro planning, injection safety, waste disposal, record maintenance and reporting.
2. Strengthen monitoring and supervision at all levels.
3. Involve other departments (ICDS, Railway, Education, PRIs) and partners (NGOs, private sector, medical colleges) more actively to communicate messages and provide services.
4. Develop a vaccine management system where vaccine requirements are based on accurate target population (from community level surveys) and working cold chain storage capacity.

## 2. BACKGROUND

Uttar Pradesh is the largest state in India. Therefore, its performance in preventing communicable diseases, including for immunization delivery, has a huge impact on overall disease transmission in India.

### DEMOGRAPHY (DATA FROM 2001 CENSUS)

Total 2001 population was 166 197 921, making it the most populous state in India. The population growth was 26% since the 1991 census; the 16th highest growth rate of the 35 States and Union Territories; the 5th highest of large States (>2.5 million population).

Uttar Pradesh population is 79% rural (72% for India). The overall gender imbalance is the 9th worst of the 35 States and Union Territories with 898 females for every 1000 males (933 per 1000 for India). Overall literacy rate is 56% (65% for India), with substantial female educational disadvantage as shown by a male to female literacy rate ratio of 1.6 (1.4 for India). Children aged under-five-years comprise 12% of the Uttar Pradesh population (11% for India).

### IMMUNIZATION

The Universal Immunization Programme (UIP) is a national programme established in 1985, built upon the Expanded Programme on Immunization (EPI) started in 1978. The UIP is delivered as part of the Reproductive and Child Health (RCH) programme. Private practitioners also deliver the UIP vaccines and offer additional vaccines.

The UIP had its last comprehensive review in 1989, with more recent but less comprehensive reviews undertaken in 1999. The 2004 UIP review was undertaken in six states. Uttar Pradesh was selected because it is a large state with low immunization coverage and large immunity gap.

### STATE IMMUNIZATION PERFORMANCE

The structure and management of the immunization system is in place but not functioning efficiently. There are plans for conducting immunization sessions on two days a week throughout the state but only about 30% of the planned sessions are being held.

Reported coverage is unreliable: 2001/2 BCG coverage in Uttar Pradesh was reported at 112% compared to evaluated coverage of 43%; reported DTP3 coverage is > 80% for the last few years, the NFHS II district coverage evaluation survey found a range from 29% in Badaun to 83% in Lucknow, with district average of 55% for the state.

Coverage performance is thus assessed through surveys. UNICEF conducted national cluster surveys covering most or all states every year from 1999 to 2002. Estimated full immunization rate in Uttar Pradesh has been about 20% for the past three years. The main reason for low coverage is poor access (with less than half receiving BCG in the past three years), but about one third of children who start immunization do not complete the series<sup>1</sup>.

In 2001, Uttar Pradesh contributed 4.7 million unimmunized infants to the pool of susceptible children; the largest in India. [Estimate from 2001 coverage

<sup>1</sup> Coverage data for the years 1999, 2000, 2001, and 2002, respectively are: fully immunized: 34%, 17%, 19%, and 22%; dropout rate (BCG or measles): 12%, 36%, 38%, and 33%; and access (BCG coverage): 58%, 46%, 43%, and 43%.

# 3. METHOD

Railway Hospital	Dr. C.D. Pathak Dr. Tejinder Singh pediatrician and in charge of immunization
Lal Kothi UHC	Urban slum dwellers
Pali Additional PHC	Dr. Singh, MO, APHC ANM
District Cold Store	Mr. N.L. Maurya, DAIO
District Health Office	Dr. Ramnath Ram, DIO
Pali Sub-centre area	2 AWWs Talked to several families
Pali Block PHC and block PHC cold chain	Dr. Mohammad Aslam, Acting MOIC Pali Block PHC Dr. N. Yadav, Immunization Officer Mr. Singh Block PHC Computer/ Investigator
Bhatwal sub-centre for immunization post	Ms. Radhika, ANM
District Magistrate	Ms. Dimple Verma, District Magistrate
Pali APHC/Pali sub center	Ms. Premlata Devi, ANM
Walk-in-Cooler, Gorakhpur	Mr. Shakeel
GP Association Vaccination Center.	
Gorakhnath UHC	Ms. Shanti Devi, PHN
Gola CHC	Dr. B P Gupta, Superintendent Dr. S P Mishra Paediatrician Dr. Laljee, Physician Mr. Pranpati, Supervisor Mr. Srivastava, Computer 20 ANMS from Gola Block
Persia Sub Center	Ms. Bimla Devi, ANM
Kakarahi Sub Center	Ms. Surveshrai, ANM
Chalwa APHC	Mr. Suresh Singh Pharmacist Mr. Sriram, Ward Boy
Kakarahi APHC	Mr. Ramnayak, Pharmacist
Khagani PHC	MOIC
Urwa PHC	Dr. Verma, MOIC  NGOs working on different blocks Madhyam, David Memorial Christian Gramin Vikas Samiti

The review provides qualitative and selective information on the immunization programme. It is not intended to be either quantitative or statistically representative. The aim was to identify strengths, weaknesses, and bottlenecks to develop practical strategies for improving routine immunization. The review also aimed to help prioritise implementation of the multi-year plan (MYP: the 2005-2010 strategic plan).

The state review was undertaken following a protocol and questionnaires developed by the national UIP review team. Annex 1 details the protocol. Sitapur, and Meerut, and Gorakhpur districts were each visited by one team, with the first team also visiting the State Headquarters. Annex 2 details the team members, their itinerary, and the main persons met.

The three teams covered Western, Central and Eastern parts of the state. Emphasis was given to visit remote sub-centres, where possible. In addition to the usual sites in the protocol, the teams also visited other government agencies (e.g. Railway Hospitals, ICDS Department, District Statistical Officer) and some NGOs. To elicit common information from ANMs, a focus group discussion was held to capture their opinion on issues like alternate vaccine delivery methods. Due to the holidays

and Pulse Polio activities the teams it was difficult for the teams to see an adequate number of sessions at the sub center and outreach sites.

Some of the key observations made by the teams are detailed in Annex 3. These observations, the completed questionnaires, and discussions between team members led to the agreement of up to three each of successes, barriers, conclusions, and recommendations for:

- Strengthening routine immunization at every level (section 4)
- Eight technical areas of protocol, to aid prioritisation for the MYP (section 5)

Further discussion led the team to agree on up to five key recommendations to strengthen routine immunization (presented in the summary); and the priority actions for the MYP (section 5).

# 4. STRENGTHENING ROUTINE IMMUNIZATION

The state review team identified up to three key successes, barriers, conclusions and recommendations for strengthening routine immunization at each level. Annex 3 includes these in more detail as well as some additional observations and recommendations.

	SUCCESSSES	BARRIERS	CONCLUSIONS	RECOMMENDATIONS
STATE	<ul style="list-style-type: none"> <li>State Task Force and core group formed for routine immunization.</li> <li>Adequate cold chain equipment.</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate political commitment.</li> <li>Poor coordination with: education, ICDS, private sector, &amp; NGOs.</li> <li>Poor vaccine logistics; irregular central supply.</li> </ul>	<ul style="list-style-type: none"> <li>All elements in place, but need political commitment and managerial capacity.</li> <li>Training is key need at all levels in priority areas [1].</li> </ul>	<ul style="list-style-type: none"> <li>Widen/strengthen Task Force; increase commitment for UIP.</li> <li>Train staff [1] and provide standard tools (e.g., Registers).</li> <li>Mandatory monthly sessions at every AWC.</li> </ul>
DISTRICT	<ul style="list-style-type: none"> <li>Effective models for social mobilisation implemented (UNICEF/CARE).</li> <li>Adequate staffing.</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate monitoring &amp; supervision; no ANM training for many years.</li> <li>Insufficient cold chain; vaccine stock-outs.</li> <li>Inadequate staff (esp. for urban &amp; peri-urban).</li> </ul>	<ul style="list-style-type: none"> <li>Same as state level (above).</li> <li>Coordination with other departments and agencies needs to be strengthened.</li> </ul>	<ul style="list-style-type: none"> <li>Implement state level recommendations (above).</li> <li>DM to regularly review performance of validated coverage data [2].</li> <li>Provide flexible funding for mobility and contingencies</li> </ul>
URBAN	<ul style="list-style-type: none"> <li>Some areas covered.</li> <li>Self motivated private practitioners (PPs) delivering UIP and willing to increase participation.</li> </ul>	<ul style="list-style-type: none"> <li>No session plans; mobile &amp; slum pops. not reached.</li> <li>Not delivered at hospitals: missed opportunities</li> <li>PPs not reporting, not coordinated.</li> </ul>	<ul style="list-style-type: none"> <li>Urgent need to increase infrastructure.</li> <li>Need to create private-public partnerships for immunization and increase involvement of PPs and NGOs.</li> </ul>	<ul style="list-style-type: none"> <li>Integrate and plan with PPs &amp; NGOs (use MOU) for service delivery and social mobilisation.</li> <li>Train private providers.</li> <li>Provide hospital service (screen for status and daily immunization).</li> </ul>
PHC	<ul style="list-style-type: none"> <li>Cold chain mostly intact and maintained up to block PHC level.</li> <li>Most sanctioned staff positions filled.</li> </ul>	<ul style="list-style-type: none"> <li>No operational funds (incl. get vaccine to ANM).</li> <li>No clear plans for hard-to-reach.</li> <li>No immunization training for &gt;10 years; supervision rare and of poor quality.</li> </ul>	<ul style="list-style-type: none"> <li>UIP is low priority for all staff.</li> <li>Vaccine supply erratic.</li> <li>Role of additional PHC for UIP not clear.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen planning to cover catchment, esp. hard-to-reach [3].</li> <li>Provide contingency funds for BPHC / PHC / SC level.</li> <li>Clearly define duties of staff and facilities; reward best performing Panchayats &amp; SCs</li> </ul>
SC	<ul style="list-style-type: none"> <li>ANM positions generally filled.</li> <li>Some volunteers active in social mobilization.</li> </ul>	<ul style="list-style-type: none"> <li>Poor service quality and reliability; little community awareness &amp; involvement.</li> <li>ANMs don't know target; large catchment for some.</li> </ul>	<ul style="list-style-type: none"> <li>Poor Service quality, incl. social mobilisation, is</li> </ul>	<ul style="list-style-type: none"> <li>Involve community [4] in planning, social mobilisation, and on fees to fund certain activities.</li> <li>Reorganize ANMs' workload to be realistic and rational.</li> </ul>

### Notes:

- [1] Priority areas for training include micro planning; injection safety, waste disposal, record maintenance and reporting.
- [2] Coverage data should be validated through supervisory visits and annual evaluations
- [3] Planning needs to have focus on appropriate strategies for hard-to-reach populations. Planning should be strengthened by involving other departments (especially ICDS, PRI); funding operational costs according to plan; and regularly reviewing performance (incl. by ICDS supervisors). The MO and other supervisory staff need to be more active in planning and monitoring.
- [4] Community involvement includes training the ANMs to make better use of volunteers, and other local resources, for planning as well as service delivery. Community leaders & Organisations like the Gram Pradhans, Mahila Mandals/MahilaSwasthya Sangh (MSS), religious leaders, and other community leaders need to be more actively involved in planning and monitoring services. Less than 30% of planned services were held.

# 5. PRIORITY AREAS FOR IMPLEMENTATION OF THE MULTI YEAR PLAN

The state review team identified up to three key successes, barriers, conclusions and recommendations on eight technical areas, detailed below. From these (and the complete set of observations and recommendations, detailed in Annex 3), the national team identified priority actions from a subset of the recommendations. With many potential priorities, the final list was limited to feasible actions most likely to have an impact in relation to the overall goal protecting children from disease.

Each priority action was linked, if possible, to one of the 20 objectives in the MYP. The objectives are numbered and given a short title here, with the full description and associated goal in Annex 5. Implementing the priority action for that objective provides a focus for implementing the MYP.

MULTI-YEAR PLAN PRIORITY ACTIONS	MYP OBJECTIVE
1. Provide support to help each district, block, PHC, and SC develop coverage improvement plan (CIP)	1.1: regular sessions
2. Develop and provide simple tools and job-aids to register and track each child, and to monitor progress, and to validate coverage	6.3: Coverage monitoring
3. Provide training and supplies for safe injection and disposal	1.5: safe injection
4. Develop state social mobilisation plan to engage community resources and ownership	4.1: social mobilisation
5. Enhance coordination with AWWs for social mobilisation and service	

In the table describing the eight technical areas, the abbreviation used is in square brackets: Service delivery & injection safety [DEL]; Surveillance & monitoring [S&M]; Vaccine distribution & logistics [LOG]; Programme management [MGT]; Cold chain

	SUCCESSSES	BARRIERS	CONCLUSIONS	RECOMMENDATIONS
DEL	<ul style="list-style-type: none"> <li>Basic supplies provided</li> <li>UIP delivered by variety of institutions and private providers.</li> <li>ANMs and AWWs collaborating in many districts.</li> </ul>	<ul style="list-style-type: none"> <li>Services irregular &amp; poor quality [1].</li> <li>No mobility support for ANMs to collect vaccine or do outreach.</li> <li>Unclear guidelines/policies</li> </ul>	<ul style="list-style-type: none"> <li>Poor service quality causes low utilization, aggravated by irregular and unpredictable delivery.</li> <li>Unsafe injections and practices leading to potential harms.</li> </ul>	<ul style="list-style-type: none"> <li>Provide training, tools, and supplies to improve service delivery and injection safety.</li> <li>Use AWCs in addition to SC for regular, predictable sessions.</li> <li>Increase delivery through hospitals, private sector and NGOs.</li> </ul>
S&M	<ul style="list-style-type: none"> <li>Coverage data regularly compiled and reported.</li> <li>Some sessions monitored by NPSP (SMO/Block Monitors).</li> <li>Quarterly state level review meeting.</li> </ul>	<ul style="list-style-type: none"> <li>Printed registers and report forms not supplied.</li> <li>Unreliable data reported; data not analyzed or used; limited tracking.</li> <li>VPDs (except AFP) and AEFI rarely reported.</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and surveillance systems need to be improved at all levels.</li> </ul>	<ul style="list-style-type: none"> <li>Provide training, tools, and supplies (e.g., registers) to improve coverage and disease surveillance.</li> <li>Use ANM registers and counter-foils.</li> <li>Supervisors to validate reported data accuracy; use external agency for evaluation; make staff accountable.</li> </ul>

LOG		<ul style="list-style-type: none"> <li>Frequent stock outs</li> <li>Vaccine supply system is "push" not related to need.</li> <li>ANMs travel 8-10 times a month to collect and return vaccines.</li> </ul>	<ul style="list-style-type: none"> <li>Supply shortages of all vaccines is a serious problem in all districts.</li> </ul>	<ul style="list-style-type: none"> <li>Use doses (not vials) for vaccine stock records.</li> <li>Provide funds (based on micro plan) to get vaccine and supplies to ANM.</li> </ul>
MGT		<ul style="list-style-type: none"> <li>Task Force not meeting regularly; needs other members.</li> <li>Roles not clearly defined; no dedicated UIP officer</li> <li>Poor planning and monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>Too much political interference at every level.</li> <li>Inadequate coordination with other stakeholders and agencies.</li> <li>No appropriate micro plans at any level.</li> </ul>	<ul style="list-style-type: none"> <li>Provide standard stock registers and temperature records/charts.</li> <li>Increase priority of UIP: senior staff to manage and review performance; collaboration with other departments, private, and NGOs to strengthen UIP.</li> <li>DIO with UIP as only duty, trained and stay in place for minimum time</li> </ul>
CC		<ul style="list-style-type: none"> <li>Insufficient cold chain space at district level; some equipment beyond repair.</li> <li>Some freezing observed in ILRs; poor CC mgt. in private sector.</li> <li>Long repair times; insufficient POL.</li> </ul>	<ul style="list-style-type: none"> <li>Cold chain is well maintained despite constraints, poor electric supply, and equipment aged.</li> <li>Guidelines needed on process for non-functional equipment.</li> <li>Overall motivation and commitment of staff are very low.</li> </ul>	<ul style="list-style-type: none"> <li>Consider auto-start power generators at critical storage points.</li> <li>Provide sufficient POL funds at all levels, and new generators where needed.</li> <li>Provide standard stabilizers for cold chain equipment.</li> </ul>
HR		<ul style="list-style-type: none"> <li>No accountability or recognition for performance; insufficient staff for workload (aggravated by PPI demands and failure to use male workers).</li> <li>Staff lack skills; no supportive supervision.</li> <li>Most ANMs non-resident security concerns and Sub Centre building not available.</li> <li>No training on immunization for many years for most staff.</li> <li>Absence of guidelines, job aides, periodic refreshers and reference materials for all levels</li> <li>Major deficiencies in injection practice</li> </ul>	<ul style="list-style-type: none"> <li>Training is an urgent priority for all levels in: UIP policies and guidelines; safe injection and disposal; vaccine and cold chain management; micro planning, including follow-up and analysis of coverage data; and record maintenance and reporting.</li> </ul>	<ul style="list-style-type: none"> <li>State to increase staffing, and rationalise allocation for workload; use contracted staff for vacant position.</li> <li>Use male workers, where present, to support RI.</li> <li>Institutionalize performance assessment and accountability mechanisms linked to rewards and recognition.</li> </ul>
TRN				
IEC				<ul style="list-style-type: none"> <li>Train all levels on coverage improvement using RED strategies, including mapping and planning at district and block level.</li> <li>Train all providers (incl. private and NGO) on service delivery.</li> <li>Create district level trainers who can train on all aspects of UIP with practical,</li> </ul>

**Notes:**

[1] Service quality poor in many areas including the lack of planning in urban areas; no follow-up; unsafe injections; poor communication; improper injection sites; and missed opportunities.

# ANNEX 1: METHOD USED FOR THE UIP REVIEW OF SIX STATES

The national UIP review team developed the methodology, and recruited 56 national and international experts (in a range of areas) to participate in the review in 13 teams reviewing six states (two in each State and three in UP). The 56 experts represented the GOI (4); CARE (6); CVP PATH (2); DFID (1); USAID (3); EU (1); CDC (2); UNICEF (13); WHO (13); STATES / ACADEMICS (10); and SHRISTI (1).

Questionnaire modules for each level (including for urban and rural health facilities and for private physicians) provided a framework to elicit information and guide observations in a standardised way. The national team developed and pre-tested questionnaires to cover eight technical areas relevant to the multi-year plan.

The teams' primary information source was through observation and questioning (as per the questionnaires). Immunization sessions were observed including at outreach sessions, wherever possible. However, the opportunity to observe sessions was limited, so most observations were based on records and the overall situation of each facility, and from discussions with the health workers. Observations included review of immunization records and reports, vaccine stocks and storage, injection supplies and disposal. Records were used to provide additional insights and validate information given to the teams,

and to cross check data (eg, coverage and vaccine utilisation data).

In addition, where possible, teams sought information from the community (mothers) and local representatives (e.g. Gram Panchayats) to understand their perception of the immunization services and their perceived needs

Each team was designed to include four (and in some cases five) individuals with a range of knowledge and skills to provide a comprehensive review of immunization in each district, and at the state level for one of the teams. Within each district, the team split into two to assess two blocks per district. The national team pre-selected the two districts to be reviewed in each State (three for UP); one with high coverage and one with low coverage (from those districts included in the 2002-3 coverage survey data).

Each team randomly selected two blocks to review. The selection was not from all the blocks, but from four blocks pre-selected by the national team. (However, Jaisalmer district only has three blocks). After reviewing the block Primary Health Centre (PHC), one randomly selected PHC in that block, and two subcentres (SCs) of the PHC were to be reviewed by each half of the team.

Each team had a briefing and debriefing at State and District levels, as well as giving feedback to all sites visited. The two (three for UP) teams consolidated their findings in their feedback to the state at the end of the visit. All teams shared their findings in Delhi to come to a consensus on the key recommendations for national level.

# ANNEX 2 : TEAM MEMBERS, ITINERARY AND PERSONS MET

**TEAM LEADER:** Mr. Vikram Singh (Gol)  
**INFORMATION FOCAL POINT:** Anne Golaz (UNICEF)  
**PRESENTER:** Dr. Karan Singh (WHO)

## TEAM 2 GORAKHPUR DISTRICT

1. Dr. Dev (UNICEF)
2. Gopa Kumar (EU)
3. Joby George (CARE)
4. Carrie Tudor (WHO)

## TEAM 1 LUCKNOW & SITAPUR DISTRICT

1. Vikram Singh (Gol)
2. Anne Golaz (UNICEF)
3. Iqbal Hussein (USAID)
4. Karan Singh Sagar (WHO)
5. Sanjay Saxena (WHO)

## TEAM 3 MEERUT DISTRICT

1. Jaya Rao (Assistant engineer - Cold Chain, Hyderabad, AP)
2. S. Wiersma (WHO)
3. Dr. YP Gupta (DFID)

## LIST OF PERSONS MET IN UTTAR PRADESH STATE LEVEL LUCKNOW

Dr L.B. Prasad, Director General (DG), Directorate General of Family and Welfare  
 Mr. Chandra Prakash, Director, ICDS, Directorate of Women and Child development  
 Dr. Pandey, State Immunization Officer  
 Mr. Pawan Kumar, State cold chain officer  
 Mr. Abishek K Sinha, Data Management Assistant  
 Mr. Martin Hansen, Monitoring and Evaluation Officer, UNICEF State Office  
 Dr. Neera Jain, assistant Project Officer, RCH, UNICEF Office  
 Dr. R.K. Pandey, Secretary of Gorakhpur Indian Academy of Pediatrics

## CARE - INDIA

Mr. Prabhakar Sinha, State Programme Manager,  
 Dr. D S Panwar, OR coordinator  
 Dr. Anupam Raizada, Regional Manager  
 Ms. Sunita Niogi, Capacity Building Officer

## DISTRICT SITAPUR

PLACES VISITED	PERSONS MET
<b>SITAPUR DISTRICT</b>	Mr. Amod Kumar, District Magistrate
CMO Office	Dr. S P Ram, CMO Dr. Arun Kumar Gautam, Dy CMO
UIP Office	Dr. A K Pandey, UIP Additional Director Dr. Manju Singh, Assistant Director UIP
District Hospital	Dr. O P Pandey, Medical Superintendent Dr. S P Singh, Pediatrician
WHO	Dr. Hemant Kharnare, Surveillance Medical Officer Dr. Pooja Saxena, Surveillance Medical Officer

UNICEF	Ms. Neelam Dubey, SMC
PPC, Mahila Chikitsalaya, Sitapur, Urban	Ms. Shashi Mishra, Lady Health Visitor Ms. Kusum Lata, Lady Health Visitor Ms. Rukmani Rathor, ANM Ms. Rameshwari Mishra ANM Ms. Munni Pandey, ANM Mr. P L Shukla, Head Office Clerk
Private Practitioners( Sitapur Urban)	Dr. S K Vaish Pediatrician Dr. Mahesh Chandra Gupta, Surgeon Dr. Renu Mahesh Obstetrics/ Gynecology
<b>NGOs</b> CARE India	Mr. S M Sharma, Demonstration Partnership Officer Mr. Rajeev Dhyani, Training Coordinator Mr. S M Baqar, Capacity Building Officer Mr. D P Gokhale, Youth Coordinator Mr. P P Shrivastava, Government Partnership Officer Mr. Sandeep Upadhyay, Monitoring Officer
DIFPSA	Ms. Suman Chandrabhan Executive Secretary, Project Management Unit, District Action Plan
Mehmoodabad CHC	Dr. A K Srivastava, Superintendent Dr. Ranjesh Kushwasa Physician Mr. A P Verma, Immunization Officer
Khurwal PHC	Dr. Vijay Verma, MOIC
Khurwal Sub center	Ms. Manju Mishra, ANM Ms. Vimla Devi ANM
AW Center Sadarpur	Ms. Naseem Bano AWW
Sidhauri CHC	Dr. B D Awasthi, Superintendent Dr. Jeeta Singh, Pediatrician Dr. Ajay Tiwari Physician
Additional PHC Ataria (Sidhauri Block)	Dr. B Dev, MOIC

## DISTRICT GORAKHPUR

PLACES VISITED	PERSONS MET
WHO	Dr. Sinha, SMO (NPSP) Dr. Vibhor Jain, SRC (NPSP)
District Health Office	Dr. Gyanendra Singh, CMO Deputy CMO Dr. Ramnath Ram, DIO

# ANNEX 3: SELECTED OBSERVATIONS AND RECOMMENDATIONS

## 1. OBSERVATIONS BY LEVEL

STATE	
<p><b>OBSERVATIONS</b></p> <ul style="list-style-type: none"> <li>▪ State Task Force &amp; RI core group formed</li> <li>▪ Adequate cold chain equipment</li> <li>▪ Inadequate political &amp; bureaucratic commitment at highest levels</li> <li>▪ Lack of functional coordination &amp; convergence between H&amp;FW, education, ICDS, private sector, &amp; NGO</li> <li>▪ Irregular supply of vaccine from center and weak vaccine management &amp; supply system</li> <li>▪ Political/bureaucratic commitment to RI needs to be strengthened</li> <li>▪ Immunization has all elements in place but significant efforts are needed to make it a top priority</li> <li>▪ Quality of service can be improved with training and periodic technical updates</li> </ul>	<p><b>RECOMMENDATIONS</b></p> <ul style="list-style-type: none"> <li>▪ Increase political/ bureaucratic commitment at State and District levels</li> <li>▪ State level Task Force should meet regularly &amp; include GOI representative, partners, ICDS, PRI &amp; other stake holders representatives &amp; conduct advocacy meetings with the district officials &amp; partners</li> <li>▪ Develop &amp; implement tools for vaccine management &amp; supply</li> <li>▪ Implement refresher training for all levels of staff</li> <li>▪ Make it mandatory to hold monthly sessions at every AWC</li> <li>▪ Make printed reporting forms and registers available on a regular basis.</li> <li>▪ To increase card retention - link Immunization cards to others public services (like admission in school, BPL)</li> </ul>
DISTRICT	
<p><b>OBSERVATIONS</b></p> <ul style="list-style-type: none"> <li>▪ UNICEF / CARE has positive experience in involving community (e.g. Social mobilization net, Change Agent, Self Help Group) to create awareness and social pressure to families to get children immunized</li> <li>▪ Adequate staffing levels in place at most levels</li> <li>▪ Inadequate monitoring &amp; supervision</li> <li>▪ Insufficient space for cold chain equipments at district level.</li> <li>▪ Inadequate mobility support</li> <li>▪ No training for ANMs since many years</li> </ul>	<p><b>RECOMMENDATIONS</b></p> <ul style="list-style-type: none"> <li>▪ Regular performance based review of the RI program by the DM</li> <li>▪ Clarification on procedure for condemnation of cold chain equipments (ILR &amp; deep freezers).</li> <li>▪ Reported coverage at every level should be validated through supervisory mechanisms. Conduct annual external evaluation at the district level</li> <li>▪ Make printed reporting forms and registers available on a regular basis for each district to use.</li> <li>▪ Increase role of NGO &amp; private sector in the urban area for service</li> </ul>

- Frequent and persistent stock outs exist at present.
- Few staff to cover rapidly growing urban and peri-urban population
- Inadequate and less effective IEC efforts
- Inter-sectoral coordination inadequate to optimize the role of other programs (Eg: ICDS)
- Bureaucratic commitment to RI

- provision and IEC
- Provide immunization services in the hospitals daily
- Provision made for flexi-funding (mobility & contingencies)
- Strengthen monitoring and supportive supervision
- Training and equipment updates urgently needed

### URBAN HC / PRIVATE PRACTITIONERS

since many of the critical elements are present

- Interagency and interdepartmental coordination needs to be strengthened

#### OBSERVATIONS

- Self motivated private practitioners willing to participate in RI
- Vaccines available in private sector
- No plan/roster for holding immunization session routinely in urban areas
- Missed opportunities due to lack of hospital based immunization services.
- Inadequate government health infrastructure (urban areas)
- Lack of hospital based immunization services
- Coverage data from private sector is not reported through Government system
- Little interaction between private and public sector (e.g. private

#### RECOMMENDATIONS

- Map out the NGO & private sector in the urban area & involve them in RI with a MOU
- Micro-planning for RI & IEC in consultation with the Private sector for creating awareness & demand & also holding regular immunization sessions.
- Provide immunization services in the hospitals daily with doctors screening of immunization status
- Provide training to immunization service providers in the Private sector

### PHC

- Mobile population and slum dwellers not systematically reached
- Urgent need to increase infrastructure in urban areas to meet

needs

- Need to create private-public partnerships for immunization
- Need to increase involvement of private practitioners and NGO

### **OBSERVATIONS**

- Cold chain mostly intact and maintained up to block PHC level
- Most sanctioned staff positions filled
- No mobility support for vaccine delivery at immunization sites
- Supervisory visits are rarely happening and the quality is poor. Role of HS /HV/ LHV etc. not defined
- No provision of flexible funds for implementation of the RI program
- ANMs' performance is assessed based only on FP achievements
- No training in immunization given > 10 years
- Number of immunization beneficiaries are not known

### **RECOMMENDATIONS**

- Medical Officer and other supervisory staff should play a more active role in planning and monitoring immunization activities in the block
- Mechanisms for joint planning and review of RI with other departments (especially ICDS, PRI) on a regular basis needs to be developed
- Funds should be made available (based on micro plan) for transportation of vaccines and logistics (e.g. AD syringe) from PHC to session sites
- Clearly laid out duties (inc. RI) for each of the health functionaries
- Contingency funds be made available for BPHC / PHC / SC level.
- Supervisory tools should be

## **SUB CENTRE**

collection

- No clear plans exist to reach out to hard-to-reach areas
- RI is a low priority activity for all staff
- Need to redefine role of additional PHC in RI
- Erratic supply of vaccine at all levels
- RI is mostly a responsibility of Health staff

### **OBSERVATIONS**

monitoring.

- Make printed reporting forms and registers available on a regular basis.
- Funds and guidelines should be made available for rewarding best performing Panchayats and sub centers
- Make it mandatory to hold monthly sessions at every AWC
- Separate micro plans required for providing regular RI outreach sessions for hard-to-reach areas

### **RECOMMENDATIONS**

- ANM positions generally filled
  - Some volunteers active in social mobilization
  - Polio has given better understanding of how to reach community
  - Ownership by community is lacking in many areas (e.g. Gram Pradhan, Panchayat).
  - Community not aware times of fixed site services
  - Large catchment area for some ANMs
  - Significant left/drop-outs:
  - ANMs do not know the target population they have to serve
  - No system to track children for continuity of services
  - No continuity from mother to child
  - Timing of vaccination not appropriate
  - Less than 30% planned sessions held due to other activities
  - Staff generally feel polio eradication
- Encourage community ownership by involving Gram Pradhans, Mahlia Mandals/MahilaSwasthya Sangh (MSS), religious leaders in:
  - Development of micro plans (including IEC/BCC strategy)
  - Organization of sessions
  - Community mobilization
  - Allowing them to decide on fee scheme for funding certain activities.
  - ANMs should make better use of volunteers and village level resources to increase coverage (e.g. AWWs, trained Dais, change agents, CMWs, TBAs, contractual ANMs (under RCH), and CBDs where available).
  - Reorganize the sub center catchment areas to make the workload on the ANM realistic and rational
  - Promote use of birth listings or registries to reduce left-outs:
  - Annual household surveys should be carried out under supervision using

## 1. OBSERVATIONS BY TECHNICAL AREA

<b>HUMAN RESOURCES</b>	
<p><b>OBSERVATIONS</b></p> <ul style="list-style-type: none"> <li>▪ Very few EPI staff vacancies at all levels.</li> <li>▪ Designated staff in charge of cold chain at all levels in the district including a refrigerator mechanic.</li> <li>▪ Inadequate UIP structure at all levels. Insufficient sanctioned posts to cover even the current population size.</li> <li>▪ Catchment population is too large to be covered by existing staff.</li> <li>▪ Insufficient UIP staff at state level.</li> <li>▪ Most ANMs do not stay in their sub center villages. ANMs feel insecure to stay in rural areas and sub center buildings are not available.</li> <li>▪ Male workers are generally not utilized for supporting RI.</li> <li>▪ Lack of technical skills of ANMS regarding RI.</li> <li>▪ Supervisory visits are irregular and supportive supervision is completely lacking.</li> <li>▪ Significant amount of staff time at all levels involved in planning, executing, monitoring and reporting PPI rounds.</li> <li>▪ No accountability of staff at all levels to ensure that every child is vaccinated on time.</li> </ul>	<p><b>RECOMMENDATIONS</b></p> <ul style="list-style-type: none"> <li>▪ Adequate manpower should be sanctioned for UIP at the State Directorate of H&amp;FW</li> <li>▪ Staffing positions need to be determined by current population size (1 ANM for every 5,000 population). Reorganize the population distribution among existing sub centers</li> <li>▪ Hire newly trained ANMs on contractual basis to fill-up the vacant positions/to meet the additional staff requirements.</li> <li>▪ Institutionalize performance assessment and accountability mechanisms linked to rewards and recognition.</li> <li>▪ Effective utilization of male workers, where they are present, to support RI.</li> </ul>
<b>PROJECT MANAGEMENT</b>	
<p><b>OBSERVATIONS</b></p> <ul style="list-style-type: none"> <li>▪ Incentive mechanisms almost non-existent to motivate staff.</li> <li>▪ Overall motivation and commitment of staff are very low.</li> </ul>	<p><b>RECOMMENDATIONS</b></p> <ul style="list-style-type: none"> <li>▪ Training on implementation of RED, mapping and planning, and supportive supervision should be</li> </ul>
<p><b>OBSERVATIONS</b></p> <ul style="list-style-type: none"> <li>▪ State level Task Force and core group formed for RI.</li> </ul>	

- District level committee/Task Force to review immunization, mostly Pulse Polio Activities.
- Many layers of senior officers (Additional Commissioner Immunization, Additional Director, CMO, Deputy CMO, and DIO) involved in immunization at the district level, UNICEF and WHO project office on specific areas.
- GOI and ICDS representatives and other stakeholders are not included as members of the RI Task Force at the state level.
- State level Task Force does not meet regularly.
- No functional convergence between H&FW and ICDS departments as well as other stakeholders such as other government agencies (Education, Railway, etc.) and private practitioners.
- No specific post for State EPI Officer or DIO in State/districts. Involvement of program managers (CMO, DIO, Block MOs) in RI activities is not adequate
- Micro planning is not based on CNA approach (house to house survey, community needs assessment jointly with community etc are missing).
- Targets for under one, under five or pregnant women are not known accurately. (Several different population figures exist which are developed at different levels.)
- District is instructed to use figures provided by the state, which are lower than the figures derived through bottom-up planning.
- There is no clear-cut mechanism for planning, monitoring of reported coverage, identification of drop outs and follow up.
- Role of supervisory level health staff carried out at all levels.
- Greater involvement of senior officials in reviewing and managing routine immunization.
- Establish collaboration with other departments (ICDS, education, etc), statistics department and private/non-government organizations to strengthen routine immunization.
- Joint orientation of AWWs and ANMS on RI
- Need for public health specialist to hold position of DIO and should be responsible only for RI.

## IMMUNIZATION SERVICE DELIVERY

LHV/HV/ etc. in RI is not clearly defined.

- All opportunities for collaborating with other departments and involving private / non-governmental agencies are not optimally used.
- Detailed bottom-up micro plans are non-existent at all levels.
- Too much political interference at every level.

### OBSERVATIONS

- Basic supplies are provided (glass syringes, needles, sterilizers, vaccine carriers, etc) at peripheral level.
- Immunization services are carried out at all levels by a variety of institutions and private providers.
- Functional collaboration exists between ANMs and ICDS staff at the lowest level in many districts
- Target population for routine vaccines not accurately identified (varying denominators) and is not based on household surveys (No one correctly knows the 0-1 year population).
- No detailed micro plans exist
- No methods of tracking drop-outs, lack emphasis on continuity of services (mother to child and completion of vaccine schedule for the child)
- Irregular and inadequate immunization services provided to the community. Service delivery is highly interrupted and irregular during the past several months, primarily due to staff engagement

### RECOMMENDATIONS

- Injection safety practices need to be corrected immediately through intensive training, follow-up and supervision.
- Regular and adequate supplies of all vaccines, AD syringes and safety boxes (or other appropriate disposal method) are required.
- AWCs should be used as sites for outreach sessions on a fixed-day, fixed-site basis in all areas in addition to SC.
- All staff to be provided with tools and training on how to develop detailed micro plans to reach and track every child.
- Provide immunization services in the hospitals daily with screening of immunization status of beneficiaries by the doctors.
- Contingency funds to be made available for BPHC/PHC/SC level.
- Urgent need to increase

in Pulse Polio activities and vaccine shortages.

- The quality of immunization service delivery is poor due to lack of injection safety (reuse of syringes both disposable and glass is common) and no proper medical waste disposal is practiced.
- Serious gaps in the knowledge, skills and attitudes relating to injection safety.
- AD or disposable syringes are not provided for routine immunization.
- No mobility support available for the ANMs to collect vaccine or to visit far off villages. Most ANMs stay outside their catchment area.
- Unclear guidelines/policies on immunization practices leading to lack of understanding of ANMs, improper injection sites and missed opportunities.
- The age of initiation and subsequent doses is often late (up to 24 months).
- No counseling given to parents about expected or unexpected reactions to vaccination or when to come for subsequent doses.
- Weak infrastructure in urban/peri-

## TRAINING

immunization sessions routinely in urban areas.

- No provision of flexible funds for implementation of the RI program.
- District hospitals/CHC/BPHCs do not provide immunization services daily.
- Community ownership lacking
- Due to Pulse Polio strategy of providing follow-up services door-to-door, the community expects RI services also to be provided in their houses by ANM.
- Poor quality of services is resulting in low utilization of immunization

infrastructure in urban areas to meet large population needs.

- Increase role of NGOs & private sector in the urban areas.
- Engage private practitioners and professional medical societies (e.g. IMA, IAP) in routine immunization services.

## RECOMMENDATIONS

- All field staff, including public /

- services.
- Current injection practices and reusable injection equipment pose potential risks to children receiving vaccines.
- Conduction of vaccination sessions are irregular and hence unpredictable for the community

**OBSERVATIONS**

- There is a functioning ANM training center in each district.

- TRAINING**
- There are periodic trainings on RCH supported by SIFPSA, UNICEF and CARE, though not exclusively on immunization.
  - Manual developed and piloted (Agra) for skill based training for MOs.
  - Most front-line staff has not received any training on immunization for many years.
  - Serious gaps in ANM skills for giving safe injections. Sterilization of reusable syringes and needles is poor. (Non-sterilized glass syringes repeatedly re-used, incorrect dosage of BCG, etc.).
  - Lack of knowledge on current immunization practices and policies related to vaccine management and cold chain maintenance.
  - Absence of guidelines, job aides, periodic refreshers and reference materials for all levels.
  - Training for all staff involved in immunization services is an urgent priority.
  - Poor motivation of staff at all levels.

**OBSERVATIONS**

- private / NGO sector providers, require immediate training on current UIP policies, guidelines and skills training related to immunization services with special emphasis on micro planning, injection safety, waste disposal, record maintenance and reporting.
- Training on and implementation of RED, mapping and planning should be carried out at the district level.
- Training for all health staff on the importance of VPD and AEFI surveillance and how to report cases to higher levels.

- Create a team of qualified trainers (TQTs) at the District level who can train on all aspects of immunization.
- Training should include practical, hands-on training followed by refreshers and supervisory support.
- Training to IOs for cold chain management.
- Training for District refrigerator (ILR/DF/WIC/WIF) mechanics at all levels.

**RECOMMENDATIONS**

- Cold Chain handlers require periodic refresher training.
- Explore the possibility of auto-start power generators at the critical storage points (up to BPHC).
- Private sector/other providers of immunization services should be included in periodic refresher training on cold chain management.

- Current inventory of cold chain equipment has adequate capacity and is well maintained.
- Refrigerator mechanic in place and district has adequate budget for

### VACCINE DISTRIBUTION AND LOGISTICS

- repairs.
- Temperature of cold chain equipment are routinely monitored and recorded.
- Generators are available and used for power back-up when no electricity.
- No foam pads in vaccine carriers.
- No printed stock registers available.
- Some freezing observed in ILRs.
- Inadequate attention paid to cold chain management at private sector storage points of government supplied vaccines.
- The response time for repairs at the BPHC level is too long (on average one month).
- Shortage of spare parts at the district/regional level.

- Provide clear guidelines on procedure for condemnation of old and non-functioning (beyond repair) cold chain equipment (ILRs & DFs).
- Provide sufficient funds for POL at all levels.
- Provide replacement generators in areas where generator is non-functioning and poor power supply.
- GOI should provide standard models of one manufacturer of stabilizers for cold chain equipment.

### RECOMMENDATIONS

- Vaccine stock records should include vaccine manufacturer in

### IEC, SOCIAL MOBILIZATION AND ADVOCACY

- equipment at district level.
- Old and beyond repair cold chain equipment and generator sets found at various levels in some places
- Insufficient provision of POL for generator sets.
- Cold chain is well maintained despite constraints, poor electric supply, and age of the equipment.

### OBSERVATIONS

- Zonal vaccine cold store is well maintained and functioning.
- Stock records are in good order.

- expiry.
- Vaccine stock records should be calculated in total number of doses by vaccine and not in vials.
- Funds should be made available (based on micro plan) for transportation of vaccines and logistics to the vaccination sites.
- Printed vaccine and diluent stock registers should be provided.
- Printed temperature records/charts should be provided.

### RECOMMENDATIONS

- First expiry first out is practiced.
- Frequent stock outs and inadequate vaccine supply for all vaccines at all levels.
- Vaccine supply system is a “push” rather than a “pull” system.
- ANMs must travel to Block PHC to collect vaccines for immunization sessions at own expense. (Have to travel to 8-10 times a month to collect and return vaccines)
- Supply shortages of all vaccines is a serious problem in all districts.

#### **OBSERVATIONS**

- Some printed materials (posters and calendars) are available, mostly related to Pulse Polio.
- Highly dedicated and partially trained (SIFPSA) volunteers available in many villages who facilitate community demand
- Functional NGOs at district and also at village level for social advocacy and community mobilization in many places

- Greater involvement of NGOs, PRIs in communicating messages on importance of routine immunization to the community.
- Government system needs to be more collaborative in involving other partners.
- Training for service providers should include aspects of attitudinal changes, interpersonal communication and user-friendly services.
- Specific routine immunization media campaign is needed at the national/state level.
- Urgent need for community ownership and other stakeholder participation in routine immunization at all levels.
- Promote the use of simple community-based monitoring tools (eg: social maps) for tracking drop-out
- ANMs should counsel mothers about the vaccination given to child, any possible reactions and what to do in such a case. This will help in reducing the dropouts in subsequent doses and resistance of community for

#### **SURVEILLANCE, MONITORING AND REPORTING**

- Lack of experience in involving community (e.g. social mobilization, Change Agent, Self Help Group) to create awareness, track left-outs and drop-outs and create social pressure to families to get children immunized.
- Lack of understanding in the community regarding vaccines other than OPV and the diseases they protect against.
- Resistance to injections is very common among some communities due to communication gap.
- ICDS staff, village leaders and

volunteers are not adequately involved in mobilizing communities and in generating demand.

- Most urban communities not aware of availability of immunization services through the Urban Health posts.
- Government system is not welcoming towards the NGO sector, which plays a significant role in mobilizing communities towards immunization programs.
- Attitudes of some service providers discriminate against certain social and religious groups (eg: Muslims/low castes).
- There is a lack of IEC materials related to routine immunization available at all levels.
- A lot more work is required to address community level barriers and improve awareness and demand for immunization services.

#### **OBSERVATIONS**

- Coverage data compiled at the block level and report submitted to

#### **RECOMMENDATIONS**

- Printed registers and reporting formats need to be made available to workers at all levels on a regular basis.
- Mother to child continuity and completion of all vaccines should be monitored through the ANM registers/counter foils.
- BPHC and District level supervisors should validate reliability and accuracy of data on a continuous basis.
- VPD and AEFI surveillance should be made mandatory and carried out at all levels under District supervision.
- Mechanism to collect coverage data and VPD/AEFI surveillance from private sector needs to be established.
- Use of external agency for evaluation of RI on a periodic basis.

# ANNEX 4: STATE PRESENTATION

The team presented comments and recommendations to the state at the end of the review. This presentation is highlighted below.

## DRAFT Talking Points National UIP Review

UP State Debriefing  
6 September 2004



## Methodology

- 6 States/13 Teams:
  - Bihar – 2 Teams
  - Jharkhand – 2 Teams
  - Madhya Pradesh – 2 Teams
  - Orissa – 2 Teams
  - Rajasthan – 2 Teams
  - Uttar Pradesh – 3 Teams

## UP Teams

- Meerut
- Sitapur/Lucknow
- Gorakhpur



## Sitapur/Lucknow Team

- State H&FW
- Sitapur District CMO Office
- District Female Hospital (PPC)
- 2 Private Practitioners
- Mahmoodabad & Sidhauri CHCs
- Kurawal Block PHC
- Ataria Additional PHC
- Hardoia, Singpur Kurawal SCs

## Gorakhpur Team

- Gorakhpur District CMO Office
- Railway Hospital
- GP Association
- District Hospital
- 4 Private Practitioners
- Gola, Kahgani, Urwa & Pali Block PHCs
- Chalwa & Kakri Additional PHCs
- Pali, Bhatwal, Kakarahi & Persia SCs

## Meerut Team

- Meerut District CMO Office
- District Hospital PPC
- 3 Private Practitioners
- Parikshitgarh & Daurala Block PHCs
- Nawal & Lawar Additional PHCs
- Lohia, Mahal, Poothi, & Shikhera SCs
- Urban HC
- SIFPSA project areas



## State



## Observations

- Successes:
  1. State Task Force & RI core group formed
  2. Adequate cold chain equipment
- Barriers:
  1. Inadequate political & bureaucratic commitment at highest levels
  2. Lack of functional coordination & convergence between H&FW, education, ICDS, private sector, & NGO
  3. Irregular supply of vaccine and problem of vaccine management & supply system

## Conclusions/Recs

- Conclusions:
  1. Immunization has all elements in place but significant efforts are needed to revitalize
  2. Immunization is not a key health priority at all levels
  3. Quality of service can be improved with training and equipment updates
- Recommendations:
  1. Increase political/bureaucratic commitment at State and District levels
  2. Increase performance monitoring using State TF
  3. Develop & implement tools for vaccine management & supply
  4. Implement refresher training

## District



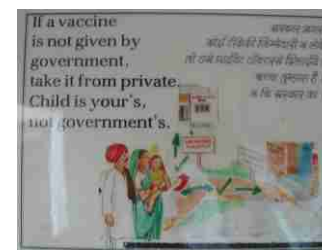
## Observations

- Successes:
  1. ANM staffing is adequate at sub-center level
  2. Functional cold chain in place for district and regional levels
- Barriers:
  1. Frequent and persistent stock outages present
  2. No staff to cover rapid periurban population growth
  3. Inadequate monitoring & supervision
  4. Inadequate mobility support
  5. IEC program weak and poorly funded at all levels

## Conclusions/Recs

- Conclusions:
  1. Political/bureaucratic commitment to RI needs to be strengthened
  2. Barriers listed can be overcome since many of the critical elements are present
  3. Interagency and interdepartmental coordination needs to be strengthened
- Recommendations:
  1. Regular performance based RI review
  2. Provision made for flexi-funding (mobility & contingencies)
  3. Need for new strategies to provide immunizations for growing urban areas
  4. Training and equipment updates urgently needed

## Urban/Private



## Observations

- Successes:
  1. Private practitioners willing to increase participation in RI
  2. Professional societies willing to participate in RI
  3. Vaccines available in private sector
- Barriers:
  1. Lack of government health infrastructure (urban areas)
  2. No session plan/roster in urban areas
  3. Lack of hospital based immunization services
  4. Little interaction between private and public sector (e.g. private associations, reporting, supply, etc)

## Conclusions/Recs

- Conclusions:
  1. Urgent need to increase infrastructure in urban areas to meet needs
  2. Need to create private-public partnerships for immunization
  3. Need to increase involvement of private practitioners and NGOs
- Recommendations:
  1. Increase role of NGO & private sector in the urban area
  2. Involve private practitioners in IEC
  3. Provide immunization services in the hospitals daily
  4. Engage private practitioners and professional medical societies (e.g. IMA, IAP)

## PHC



## Observations

- Successes:
  1. Cold chain mostly intact and maintained up to block PHC level
  1. Most sanctioned staff positions filled
- Barriers:
  1. No training in immunization given >10 years
  2. Number of immunization beneficiaries are not known
  3. No mobility support for vaccine delivery at immunization sites
  4. Role of HS /HV/ LHV etc. in RI is not defined
  5. No provision of flexible funds for implementation of the RI program
  6. FP targets are major focus of monitoring and feedback while immunization is not prioritized at all levels



## Conclusions/Recs

- Conclusions:
  1. Weak monitoring of routine immunization
  2. Need to redefine role of additional PHC role
  3. Erratic supply of vaccine at all levels
  4. Waiting time long for ANM vaccine collection
- Recommendations:
  1. Increase funding for transportation of vaccines and logistics from PHC to session sites
  2. Clearly laid out RI duties for each of the health functionaries
  3. Contingency funds be made available for BPHC/PHC/SC level
  4. Increase involvement of NGOs

## SC



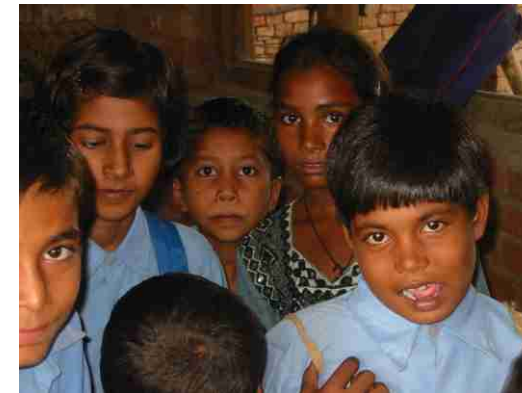
## Observations

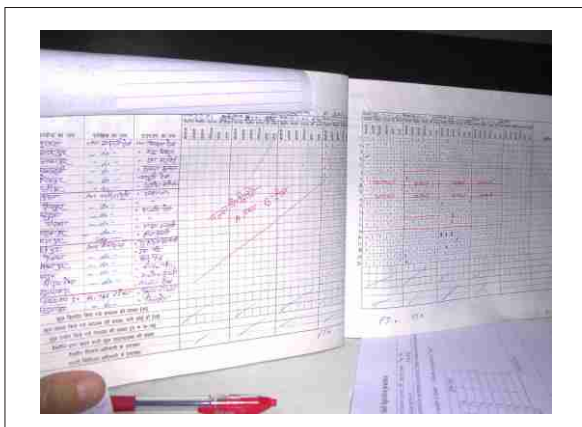


- Successes:
  1. ANM positions generally filled
  2. Some volunteers active in social mobilization
  3. Polio has given better understanding of community
- Barriers:
  1. Ownership by community is lacking in many areas (e.g. Gram Pradhan, Panchayat).
  2. Large catchment area for some ANMs
  3. Less than 30% planned sessions held due to other activities
  4. No system for tracking left/drop-outs
  5. No training for ANMs
  6. Staff generally feel polio eradication having negative effect on RI
  7. Community not aware times of fixed site services

## Conclusions/Recs

- Conclusions:
  1. Planned sessions not occurring
  2. Lack of community ownership
  3. Weak record keeping and reporting
  4. Supportive supervision is lacking
- Recommendations:
  1. One ANM post should be sanctioned for every 5,000 population
  2. ANM and AWW should not be involved in other activities on session days
  3. Track drop-outs to increase fully immunized children
  4. Better link CMC, CBD, trained Dais, AWWs with health delivery
  5. Make reporting forms available
  6. Promote use birth listings or registries to reduce left-outs





# ANNEX 5: GOALS AND OBJECTIVES OF THE 2005-2010 MULTI-YEAR PLAN FOR THE UIP

## GOAL 1 - DISTRICTS WILL PROVIDE EFFICIENT AND SAFE IMMUNIZATION SERVICE TO ALL INFANTS AND PREGNANT WOMEN

Objective 1.1: [regular sessions]	To ensure regular quality immunization sessions are planned and held.
Objective 1.2: [adequate staffing]	To ensure adequate trained staff are empowered to provide essential quality immunization services.
Objective 1.3: [cold chain]	To keep an annually upgraded inventory of cold chain according to the levels of the network, allowing for new equipment, substitution, replacement, spare parts, fuel and others in order to maintain a functional status of 90%.
Objective 1.4: [logistics]	To ensure an efficient vaccine and injection equipment management and logistics system to forecast and deliver adequate supplies of vaccines in a timely manner.
	To ensure the implementation of safe injection practices and

## GOAL 2 - CONTRIBUTE TO GLOBAL POLIO ERADICATION, MEASLES MORTALITY REDUCTION AND NEONATAL TETANUS ELIMINATION

Objective 2.1: [polio eradication]	To achieve polio eradication certification by 2007
	To eliminate neonatal tetanus (NNT) by 2009
Objective 2.2: [MNTE]	
Objective 2.3: [measles]	To reduce measles mortality by two-thirds by 2010, compared to 2000 estimates.
Objective 2.4: [Vitamin A]	To achieve and maintain a level of 70% coverage with two doses of vitamin a supplementation to children under three.

## GOAL 3 - THE UIP WILL HAVE SUFFICIENT AND SUSTAINABLE FUNDING WITH ESTABLISHED ADEQUATE, ACCOUNTABLE AND EFFICIENT FUND

Objective 3.1: [adequate finance]	To ensure adequate and reliable financial resources at national, state and local levels for the UIP to achieve goals and objectives.
Objective 3.2: [political]	To ensure political commitment for adequate annual funding

**GOAL 4 - THERE IS SUSTAINED DEMAND AND REDUCED SOCIAL BARRIERS TO ACCESS IMMUNIZATION SERVICES**

Objective 4.1: [social mobilisation ]	To ensure widespread support by all families and communities and to ensure that all eligible children and pregnant women are immunized.
Objective 4.2: [advocacy]	To ensure high level political and administrative support for immunization as the key public good.

**GOAL 5 - ACCELERATED INTRODUCTION OF LICENSED NEW AND UNDER UTILIZED VACCINES AGAINST DISEASES WITH SIGNIFICANT MORTALITY AND MORBIDITY IN INDIA**

Objective 5.1: [new vaccine]	To ensure institutional mechanisms are in place to adequately obtain, review and utilize information for deciding on introduction of new and under utilized vaccines.
Objective 5.2: [consider MMR]	To review need for MMR or MR vaccine in India's immunization programme.
Objective 5.3: [consider JE]	To review need for introduction of Japanese encephalitis (JE) vaccine in selected states.
Objective 5.4: [implement]	To implement a phased introduction of Hepatitis B vaccine.

**GOAL 6 - TO MONITOR AND USE ACCURATE, COMPLETE AND TIMELY DATA ON VACCINE PREVENTABLE DISEASES, AEFIS AND ANTIGEN COVERAGE AND DROP OUT RATES BY DISTRICT**

Objective 6.1: [disease surveillance]	To institutionalize surveillance for vaccine-preventable diseases and early detection of any outbreaks.
Objective 6.2: [AEFI surveillance]	To strengthen vaccine quality and injection safety by developing a monitoring system for reporting and responding to adverse events following immunization (AEFI) by 2009.
Objective 6.3: [coverage monitoring]	To establish an effective, efficient, complete and timely immunization recording and local area monitoring system by 2009.



## DISTRICT MEERUT

PLACES VISITED	PERSONS MET
CMO Office	Dr. A K Tyagi, CMO Dr. Sukhvir Singh DIO Dr. Y K Gupta Dy. CMO Dr. Gyanender Singh, Dy CMO Mr. Ra huveer Sin , DEIO
District PPC	Dr. Sarala Jain, SMO Dr. Amita Garg, MOIC Dr. Shalini Tiwari, Pediatrician
Medical College	Dr. Usha Sharma, Principal Dr. D K Sharma, Head of Pediatric <u>Dept.</u>
Private Medical Practitioners	Dr. Ajay Jain, President I AP Dr. Rajeev Prakash, Pediatrician Dr. V K Garg, Pediatrician Dr. PPS Chauhan, Pediatrician
PHC (Parikshatgarh) Block	Dr. Ravi Prakash, MOIC Dr. K V Prakash, MO Mr. Pramod Kumar Tyagi ICC Mr. N K Srivastava, IO
PHC (Daurala) Block	Dr. V V Sharma MOI/C Mr. Baburam ICC Mr. A P Singh IO
Additional PHC (Lawar)	Dr. V K Gupta, MO VC
Additional PHC (Nawal)	Dr. Dharamvir Sin h
Tehsil Health Post (Urban)	Dr. Sumita Goel, MOIL Dr. Pooja Sharma, MO
Poothi Sub Center	Ms. Pushpa Devi, ANM Ms. Sh ama CBD Worker
Sikhera Sub Center	Ms. Shyamavati ANM
Mahal Sub Center	Ms. Madhu ANM Ms. Neera', CBD Worker
Lawar Sub Center	Ms. Santhosh Yadav, ANM
Bahadurpur Cooperative Diary Project	Ms. Manish, ANM Ms. Amita Sharma, CBD Worker
DIFPSA	Mr. Ramesh Menon, Project Manager
WHO (NPSP)	Mr. Ashutosh Arora, AA Mr. Yakub Vaid, Consultant