**Summary of the approach to conducting the Intensified Mission Indradhanush (IMI) case-study in India**

The case-study was led and coordinated by the Ministry of Health and Family Welfare (MOHFW). A steering committee under leadership of the Joint Secretary, Reproductive and Child Health was formed and a country working group under leadership of the Deputy Commissioner for Immunization. A team comprised of technical experts in immunization, public health and research was responsible developing the protocol for the case-study, data collection and analysis. A modified multistakeholder dialogue approach was used including: [1, 2]

1. Desk review of available data, including: national health coverage surveys, implementation guidelines, standard operating procedures, performance reports from states and districts, monitoring reports and other programmatic documents.

2. In-depth and informal interviews with key stakeholders from the national and state levels and from five randomly selected IMI districts (Annex 1). Sampled districts represented a cross-section of different socio-cultural and geographic regions of the country. In each district, high performing, low performing and vulnerable population areas were selected. Two hundred stakeholders involved in planning, implementation and monitoring of IMI were interviewed using qualitative interview guides organized by thematic area and summarized using a standard format (Annex 2).

3. Analysis of stakeholder interviews using a modified Framework Method for comparing and contrasting large-scale textual data across cases.[3] Similarities and differences in the data were identified and relationships drawn across different parts of the analysis, resulting in descriptive or explanatory conclusions by theme. A health systems framework was developed populated by main policy and programme inputs across all interviews.

4. A multi-stakeholder meeting to review and discuss of findings with key health and development partners and stakeholders to review and agree on the main findings.

[1] Frost L, Hinton R, Pratt BA, Murray J, Arscott-Mills S, Jack S, et al. Using multi-stakeholder dialogues to assess policies, programmes and progress for women's, children's and adolescents' health. Bull World Health Organ. 2016 May 1;94(5):393–395.

[2] PMNCH. Methods guide for country case studies on successful collaboration across sectors for health and sustainable development. 2018. http://www.who.int/pmnch/knowledge/case-study-methods-guide.pdf

[3] Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol*. 2013;13(1):117. doi: http://dx.doi.org/10.1186/1471- 2288-13-117 PMID: 24047204.

**Annex 1: Country case study development Protocol: Documentation of Intensified Mission Indradhanush (IMI) in India**

1. **Background:** PMNCH has identified 12 country case studies through a global call for proposals on cross-sectoral collaboration, innovative practices, facilitating factors, results of the collaboration and lessons learned. These case studies will be published as a special issue in the BMJ and launched at a Partners' Forum in New Delhi India in December 2018. The case studies will facilitate sharing lessons across countries to inform action. Intensified Mission Indradhanush (IMI) from India has been selected as one of the case studies. The theme of the IMI case study is ***Quality, Equity and Dignity in Services***.

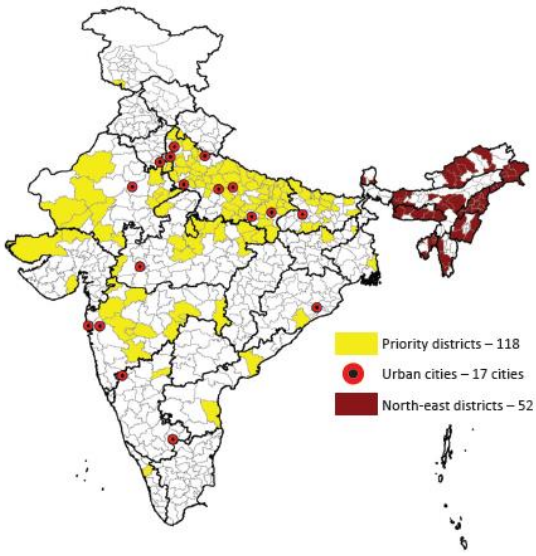
   **Mission Indradhanush (MI):** Committed to improving immunization coverage and addressing the equity agenda, the Ministry of Health & Family Welfare, Government of India, has implemented various intensification strategies including its flagship programme "Mission Indradhanush" launched in December 2014, and delivery system strengthening exercises through improved micro-plans. Mission Indradhanush aimed to fully immunize more than 90% of newborns by 2020 through innovative and planned approaches to reach all children. It not only aimed to rapidly increase the immunization coverage through special drives during specified months but also focused towards strengthening health systems for addressing equity issues in access to immunization. Under Mission Indradhanush all the vaccines provided under Universal Immunization Programme were administered to children and pregnant women. A total of 528 districts were covered during the four phases of Mission Indradhanush: *Phase-1* **(**April'15 to July'15- 201 districts); *Phase-2* **(**October'15 to January'16- 352 districts); *Phase-3* **(**April'16 to July'16- 216 districts); *Phase-4* Feb'17 to May'17 in NE states- 68 districts and April'17 to July'17- 186 districts).

   The first two phases of Mission Indradhanush contributed to an increase in Full Immunization Coverage (FIC) of 6.7%, as evidenced by Integrated Child Health and Immunization Survey (INCHIS). It was realized that this pace would not be sufficient to achieve FIC of >90% of newborns by 2020 as aimed under Mission Indradhanush. Further, FIC in selected districts/cities have shown slow progress in spite of repeated phases of Mission Indradhanush.

   Recognizing the impact of Mission Indradhanush in improving FIC across the districts over the three phases, Hon'ble Prime Minister through the PRAGATI platform, emphasized the need of a supplemental aggressive action plan to cover all left outs and drop outs in select districts and urban cities with low routine immunization coverage in a specific time-frame (December 2018). Thus the Intensified Mission Indradhanush (IMI) was initiated, targeting FIC >90% by end of 2018 in high priority areas. IMI included a comprehensive gap analysis with strengthened involvement of relevant non-health departments and enhanced accountability frameworks. IMI also aims to sustain the gains through strengthening health systems and microplanning by incorporating IMI sessions into Routine Immunization microplans.

   The key activities under IMI are:
   - Focus on urban slum areas and districts where there is maximum scope of improvement in immunization coverage
   - Due-listing of beneficiaries on the basis of robust head –count surveys which will be validated by supervisors; and
   - Improving mobilization of beneficiaries.

The districts/urban cities have been selected using criteria: (1) estimated no. of children who missed DPT3/Pentavalent3 >13,000 OR (2) DPT3/ Pentavalent 3 coverage <70%. Using these criteria, the weakest 118 districts, 17 urban cities and an additional 52 districts in North Eastern states with highest number of left outs and drop outs. The Intensified Mission Indradhanush immunization drive, comprised 4 rounds of immunization in the selected districts and urban cities. Each round lasted 7 days starting on 7th day of the month. These 7 days do not include the routine immunization days planned that week.




- Round 1 – 7th October 2017
- Round 2 – 7th November 2017
- Round 3 – 7th December 2017
- Round 4 – 7th January 2018

**Collaboration with other Ministries/ Department/Agencies:** Partnership with 12 different ministries and concerned departments is being leveraged to implement the IMI strategy. These miniseries are: Women & Child Development (WCD); Panchayati Raj; Urban Development; Sports & Youth Affairs; Human Resource Development; Education; Minority Affairs; Information & Broadcasting; Defense; Railways and Home Affairs. With support from the ministries and departments, several key mobilizers (NGOs, Public Relations, CSOs, Rotary International, NSS, NCC, Nehru Yuva Kendra, MSW, and others) have been involved. The key partners including WHO, UNICEF, UNDP, Global Health Strategies, IPE Global, Rotary International, Technical Support Units (TSUs) in select states have been supporting the IMI activities.

Under IMI, the focus has been on updating the microplan and beneficiary due list and special emphasis has been given to:

- Vacant sub centres- ANM not posted/absent for more than 3 months
- Unserved/low coverage pockets
- Sub-centre/ANM catering to populations much higher than norms.
- Villages/areas with three or more consecutive missed routine immunization sessions;
- High-risk areas (HRAs) identified by the polio eradication programme including:
  - Urban slums with migration
  - Nomadic sites (Brick kilns, Construction sites, Other migrant settlements, Underserved and hard-to-reach populations)
- Areas with low routine immunization coverage identified through measles outbreaks, cases of diphtheria and neonatal tetanus in the last 2 years.

2. **Objective:** The current activity is mandated to:

2.1. document the processes, progresses, lessons learned related to the IMI.
2.2. document the contributions, perceptions, practices, experiences and challenges from different stakeholders to capture the cross-sectoral and multi-stakeholder engagement related to the IMI from different regions of the country.

2.3. prepare a working document and a manuscript for publication in the BMJ.

The case study is expected to provide information about the **inspiration, insight,** and **ideas** into what worked and why, as well as the challenges addressed. The key components to be addressed are:

- *How is collaboration across sectors taking place in countries?*
- *What innovative practices are emerging?*
- *What conditions lead to success?*
- *What are the results of collaboration across sectors and impacts for people's health and sustainable development?*
- *What can we learn?*

For the IMI case study, the focus documentation must be done using the **Quality, Equity and Dignity** lenses.

3. **Methodology:** The documentation process shall be comprised of three key activities: (1) Desk review; (2) Field visit for interaction with stakeholders at various levels and (3) Synthesis of the findings and stakeholder review.

3.1. **Desk review:** A desk review of the IMI activity shall be undertaken based on the available documents including but not limited to implementation guidelines, SOPs, performance reports from states and districts, monitoring reports and other programmatic documents. The MOHFW shall facilitate availability of the desired documents for desk review. The documents provided by MOHFW and partner organizations related to IMI shall be reviewed and analyzed. The indicators on planning, training, implementation, coverage, monitoring and supervision, coordination, and financing shall be documented.

3.2. **Field visit for interaction with stakeholders at various levels:** To document the cross-sectoral perspective and multi-stakeholder engagement related to the IMI, we propose undertaking field visit for obtaining and in-depth understanding of the key issues of focus related to IMI implementation.

3.2.1. *Selection areas for field visit:* For the district and state level processes, we propose visits to a total of five randomly selected districts/areas (table 1). The five districts are:

- Uttar Pradesh/Bihar/Rajasthan/Madhya Pradesh (two districts out of 90 districts in IMI)
- North east states (one district out of 52 districts in IMI)
- Rest of India (all other states) (one district out of 28 districts in IMI)
- Urban areas (one area out of 17 urban areas in IMI)

We hope that these proposed districts shall provide insight into the implementation, the cross-sectoral perspective and multi-stakeholder engagement related aspects of IMI.

**Table 1: Plan for selection of districts for the IMI case study**

| Zone/states | Selected districts |
|---|---|
| Four majors<br>(Uttar Pradesh/Bihar/Rajasthan/Madhya Pradesh) | Muzaffarnagar (UP) and<br>Darbhanga (BH) |
| North east states | East Khasi (MG) |
| Rest of India (all other states) | Mallapuram (KE) |
| Urban | Indore (MP) |

These districts and urban area represent different socio-cultural and geographic regions of the country.

3.2.2. *Team members:* Each of the selected districts/urban area shall be visited by a team of experts (2 teams with 2 members each) for collecting the desired information. The team shall be comprised of researcher academicians with expertise in qualitative research, public health and immunization. The team shall coordinate with the national and state program managers for scheduling the field visits.

3.2.3. *Interaction with the key stakeholders:* We propose conducting in-depth interviews and informal interactions with key stakeholders involved in planning, implementation and monitoring at various levels to capture the desired information. The indicative list of stakeholders from different levels is given below.

*Selection of the stakeholders (table 2):*

- *State level stakeholders:* Within each state, the state level stakeholders shall be selected in consultation with the state Immunization Officer.
- *District level stakeholders:*
  - In the four districts (Muzaffarnagar, Darbhanga, East Khasi and Mallapuram), three areas shall be selected: two rural blocks (one performing well and another under-performing) and one urban planning unit (where more new sessions were added during IMI).
  - From each of the sampled blocks/areas, the following stakeholders shall be identified for interaction:
  - *Rural block (performing well):* MO (1), ANM (1), ASHA (1), AWW (1), PRI (1), Mother 2 (utilizer-1 and non-utiliser-1)
  - *Rural block (under- performing):* ANM (1), ASHA (1), AWW (1), PRI (1), Mother 2 (utilizer-1 and non-utiliser-1)
  - *Urban area (with new sessions added):* MO (1), ANM (1), AWW (1), Mother 2 (utilizer-1 and non-utiliser-1)
  - *The ANM, ASHA and AWW should be from different PHC areas.*
- *Urban district (Indore):* two areas shall be selected: two urban wards (one performing well and another under-performing) and one unit with a vulnerable population (where more new sessions were added during IMI). From each of the sampled wards/areas, the following stakeholders shall be identified for interaction:
  - *Area/ward-1 (performing well):* MO (1), ANM (1), ASHA (1, if available), AWW (1), PRI (1), Mother 2 (utilizer-1 and non-utiliser-1)
  - *Area/ward-2 (under-performing):* ANM (1), ASHA (1, if available), AWW (1), PRI (1), Mother 2 (utilizer-1 and non-utiliser-1)

- *Area/ward-3 (area with more vulnerable population):* MO (1), ANM (1), ASHA (1, if available) AWW (1), Mother 2 (utilizer-1 and non-utiliser-1)
    - Team members may decide to add stakeholders, as per need. The interactions may be formal and/or informal in nature to capture the free form of expression. The mode of interaction shall be decided by the team members based on the field conditions.

**Table 2: IMI Country Case-Study- India: Stakeholder Mapping**

| Level | Stakeholder category | Designation | Number |
|---|---|---|---|
| National | Policy makers & program managers | Joint Secretary, Deputy Commissioner, Consultant | 3 |
| | Partners/National Task force members | WHO, Unicef, UNDP, ITSU, GHS | 5 |
| | Other Ministries | WCD, Sports & youth, Urban development, Minority affairs | 2 |
| | Collaborators | Rotary | 1 |
| | For national level | | 10-11 |
| State | Health | Secretary/MD-NHM, SEPIO, RCHO, State store in-charge | 4 |
| | State Task force | WHO/RTL/SMO, Unicef, UNDP | 3 |
| | Other departments | WCD, Sports & youth, Urban development, Minority affairs | 2-3 |
| | For each state | | 9-10 |
| District & sub-district | Administration | DM | 1 |
| | Health | DIO*, CMO, Store in-charge | 3 |
| | Partner | SMO*/SM network coordinator | 1 |
| | Implementers | PHC MO (1), ANM (2-3), ASHAs (2-3) | 5 |
| | Mobilisers | AWW (2), CDPO (1), facilitators (NSS, Youth groups, NGOs, Rotary club, Lions club (1-2) | 4-5 |
| | | PRI members | 1-2 |
| | Other departments | WCD, Sports & youth, Urban development, Minority affairs | 1-2 |
| | Beneficiaries | Mothers- Utilisers (2-3)<br>Mothers- Non-utilisers (2-3) | 4-6 |
| | For each district | | 20-24 |
| | | | |
| * DIO & SMO- IDIs to be conducted | | | |

*Note: ANM: Auxiliary Nurse Midwife; ASHA: Accredited Social Health Activist; AWW: Anganwadi worker; CDPO: Child Development Program Officer; CMO: Chief Medical Officer; DIO: District Immunization Officer; DM: District Magistrate; GHS: Global Health Strategies; ITSU: Immunization Technical Support Unit; MD-NHM: Mission Director- National Health Mission; NGO: Non-government organisation; NSS: National Social Service; PHC MO: Primary health centre medical officer; RCHO: Reproductive and Child Health Officer; RTL: Regional Team Leader; SEPIO: State Expanded Program on Immunization Officer;*

*SM Network: Social Mobilisation Network; SMO: Surveillance Medical Officer; UNDP: United Nations Development program; WCD: Women and Child Development*

3.2.3.1. *Data collection:* From the identified stakeholders, information about the planning, training, implementation, monitoring and supervision, coordination within the health and across sectors and stakeholders, coverage and financing shall be explored. The IDIs/ informal interactions shall be done using a guide addressing domains appropriate for the different levels. The interview/interactions shall be audio-recorded and the team shall make field notes. If the team members feel and/or based on the requirement, the team can decide for informal interaction to obtain more realistic input/feedback from various stakeholders.

*3.2.4.* Summarization of the expert assessment: After completion of the field activities, the team members shall summarize the findings under the specific domains/issues identified (given below).

1. *Planning process (including microplan, beneficiary listing)*
2. *Human resources (including training, deployment and motivation)*
3. *Logistics and supply (for vaccines and supplies, adequacy/stock out )*
4. *Delivery (session organization, conduct, turnout, coverage)*
5. *Monitoring, supervision, reporting*
6. *Cross-sectoral coordination*
7. *System strengthening and sustainability*
8. *Client response (acceptability, social mobilization, hesitancy, resistance)*

An overall summary assessment report shall be compiled by the team of experts in consultation among themselves including the findings from all the interactions with the identified stakeholders. The summary report shall be summarized by the team in the following headings.

*Focus shall be given for the quality, equity and dignity and cross-sectoral collaboration*

1. What worked for IMI?

- Strengths of the IMI program (including the innovations used)
- How cross-sectoral coordination worked and what more could have been done?
- Any innovation used

2. What did not work for IMI?

- Challenges/weaknesses of the IMI program and the potential reasons
- Any suggestion for improvement

3. How did IMI contribute to system strengthening?

- Impact on the program/health system (immunization and other programs)

The summary report shall be sent by the team to INCLEN office.

3.3. **Synthesis of the findings:** Based on the above key questions, the core team shall synthesize the overall assessment of the districts/area and collate the report. The findings and lessons shall be used to develop two documents: (a) a detailed working report and (b) manuscript for BMJ journal.

3.3.1. *Drafting of the working document/report:* A working document shall be drafted based on the desk review and field visit findings. This document shall be shared with the MOHFW and core partner group for feedback and finalisation.

The working document/report shall include the following:

- Programme description
- Leadership, political will/ownership, monitoring at highest level
- Context, challenge and stakeholders
- Framing the issue and planning action
- Implementation architecture and mechanisms
- Monitoring, accountability
- Results (program output) (QED framework)
- Learning (challenges, facilitation)
- Innovations (specific case studies)
- Evolution, scale and sustainability
- Conclusion, case study process & additional information
-

The report shall follow a ***results chain framework*** to identify and describe the results of ***collaboration across sectors*** as given below.

| Collaboration | Implementation | Knowledge | Policy | Service/ coverage | Health/societal/ sustainable development impacts |
|---|---|---|---|---|---|
| • Joint vision and shared purpose<br>• Shared resources and responsibilities<br>• Cooperation and mutual support<br>• Achieve more together than separately<br>• Collaboration mechanisms or networks set up or strengthened<br>• Leadership and awards/ recognition | • Time (prevention or reduction of duplicative activities or services)<br>• Value for money (cost-effectiveness)<br>• Human resources (motivation, skills, retention of staff)<br>• Capacity-strengthening of local community or government to manage across sectors | • Problem definition/ understanding<br>• Research or M&E methods developed or used<br>• New evidence/ findings generated<br>• Publications and papers<br>• Knowledge networks established<br>• Communication | • Policy-making inputs at different levels<br>• Policy change results<br>• Policy networks<br>• Political capital | • Types of services<br>• Reach/coverage of services<br>• Quality of services<br>• Efficiency and effectiveness of services<br>• Equity of services | • Health outcomes (e.g. Global Strategy - Survive, Thrive & Transform targets)*(required)<br>• Sustainable development outcomes (e.g. SDGs)<br>• Community engagement<br>• Knowledge, attitudes and behaviours<br>• Equity, gender equality and human rights |

3.3.2. *Drafting of the manuscript:* A manuscript shall be drafted based on the working document drafted, which shall be circulated to the MOHFW and core stakeholder group for feedback and finalization. The finalized manuscript draft shall be submitted to BMJ.

4. **Governance:** The process shall be steered and monitored by MOHFW as per the following:

4.1. **Steering committee:** A steering committee under leadership of Joint Secretary (RCH) with membership from program division MOHFW, representation from key partners (WHO, Unicef, UNDP, ITSU), representation from supporting ministries, and technical experts.

4.2. **Country working group:** A country working group under leadership of DC, Immunization and Chairperson of core technical team with members from program division MOHFW, partners (WHO, Unicef, UNDP, ITSU) and core technical team members.

4.3. **Core technical team:** The team is represented by technical experts in immunization, public health and research from India and international and technical advisors from PMNCH. This team shall be responsible for desk review, field visit and data collection, analysis and drafting of the working document and manuscript.

**5. Timeline:**

| Sl | Activity | April | May | June | July | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Preparation | | | | | | | | | |
| 2 | Desk review | | | | | | | | | |
| 3 | Field visits & data collection | | | | | | | | | |
| 4 | Data analysis | | | | | | | | | |
| 5 | Working document | | | | | | | | | |
| 6 | Manuscript | | | | | | | | | |
| 7 | Submission/Publication | | | | | | | | | |

**Annex 2: Qualitative interview guides: IMI in-depth interviews with stakeholders**

**TOOL 1: CASE STUDY ON INTENSIFIED MISSION INDRADHANUSH (IMI) IN INDIA**
**DISTRICT ASSESSMENT SUMMARY REPORT**
**(FOR STATE, DISTRICT AND SUB-DISTRICT HEALTH AND NON-HEALTH STAKEHOLDERS)**

**Name of District: …… Name of State: ……**
**Stakeholder (Designation): ……..**
**Place of posting: ……..**
**Date of Interaction:** ……..

1. **In you view, what are the highlights/ unique features of IMI?**
   Probe: How was IMI different from RI?
   1.1 planning/ microplan (gap analysis, beneficiary mapping)
   1.2 Logistics (vaccine and supplies stock and transportation to sessions, eVIN)
   1.3 Coordination between different levels in health department
   1.4 Inter-sectoral coordination (district administration, other departments- ICDS, education, urban affairs, sports and youth, panchayati raj, Railway/army, Rotary, NGOs)
   1.5 Supervision and monitoring
   1.6 Financial provisions
   1.7 Innovations adopted
   1.8 What are your suggestions for improvement/ making IMI more effective?
   1.9 Any other input

2. **In you view, what was the quality of implementation?**
   Probe: 2.1. Intensity
   2.2. Beneficiary listing
   2.3. Service coverage

3. **In you view, to what extent the program succeeded in achieving equity?**
   Probe: 3.1. Reaching all sections and all communities
   3.2. Unreachable population/areas
   3.3. Modes of reaching the unreached/underserved/vulnerable groups

4. **In you view, to what clients were given due respect and dignity during the sessions?**
   Probe: 4.1. Facilities at sessions
   4.2. Behaviour of the health staffs and other staffs

5. **What were the innovations were adopted during the IMI sessions?**
   Document the innovations adopted and the challenges addressed

6. **How the service delivery was validated?**
   Probe: 6.1. Reporting and timeliness
   6.2. Supervision, monitoring feedback and review
   6.3. Action taken based on the feedback

7. **In your view, what impact did IMI have on health systems, health services and sustainability?**
   Probe: 7.1. Impact on the immunization service and program

7.2. Impact on other child health and maternal; health services
7.3. Sustainability of the processes and innovations adopted
(These issues are to be explored for the period after IMI and on long term)

**8. Quotable quotes**

**TOOL 2: CASE STUDY ON INTENSIFIED MISSION INDRADHANUSH (IMI) IN INDIA**
**DISTRICT ASSESSMENT SUMMARY REPORT**
**(FOR MOTHER: UTILISER)**

**Name of District: ..... Name of State: .....**
**Stakeholder type:** Pregnant women ☐ Mother of child ☐
**Place (Village/Area): ..... Block: .....**
**Date of Interaction:** .....

***Please ensure that the stakeholder (pregnant woman or the child of the woman) received vaccination during IMI period (Oct 2017-Jan 2018)***

1. **Please let us know about the *routine* immunization services available in your area for children and pregnant women?**
   Probe: Ask about the routine immunization services
   1.1 Place of vaccination
   1.2 Day and time
   1.3 Vaccinator (ANM) and supporting workers (ASHA and AWWs)
   1.4 Mode of information/ mobilisation

*Now tell us about your experience for the last episode of vaccination for your child/ yourself (if pregnant woman) during the IMI period (October 2017-January 2018).*

2. **How were you informed about the last immunization for yourself/ your child (during IMI period)?**
   Probe: 2.1. Who informed
   2.2 When and how
   2.3 Any public announcement system used?
   2.4. Was any house visit made by ASHA/AWW/ANM for checking the immunization status?

3. **Was there any special/additional effort done to go for the immunization (on the previous day or same day)?**
   Probe: 3.1. Any reminder by person or by phone or any other announcement method

4. **How was your opinion and experience about the immunization session organisation?**
   Probe: 4.1. Place where session was organised
   4.2. Facilities for sitting/waiting
   4.3. Privacy for vaccinating pregnant women

5. **How were you treated during the immunization session and process?**
   Probe: 5.1. Behaviour of ANM/ASHA/AWW
   5.2. Any mistreatment to you or any other beneficiary
   5.3. Any difference from the routine immunization session, if attended earlier
   5.4. Overall satisfaction

6. **How the ANM/ASHA/AWW behave/ treat you (and/or others in your locality) and others in your neighbourhood usually (apart from the immunization session)?**

Probe: 6.1. Any mistreatment to you or any other beneficiary
6.2. Any difference in treatment from others
6.4. Overall satisfaction

7. **Are you aware of any child/pregnant women in your locality or whom you know or who are not able to come, who don't want to come for immunization? If yes, why?**
   Probe: 7.1 Any beliefs, rituals or rumors
   7.2. Any health concerns or fear or side effects
   7.3. Any logistic/access related problem
   7.4. Any other socio-cultural reasons

8. **Quotable quotes**

**TOOL 3: CASE STUDY ON INTENSIFIED MISSION INDRADHANUSH (IMI) IN INDIA**
**DISTRICT ASSESSMENT SUMMARY REPORT**
**(FOR MOTHER: NON-UTILISER)**

**Name of District: …… Name of State: ……**
**Stakeholder type:** Pregnant women ☐ Mother of child ☐
**Place (Village/Area): …….. Block: ……**
**Date of Interaction:** ……..

***Please ensure that the stakeholder (pregnant woman or the child of the woman) who was eligible, but did not receive vaccination during IMI period (Oct 2017-Jan 2018)***

1. **Please let us know about the immunization services available in your area for children and pregnant women?**
   Probe: Ask about the routine immunization services
   - 1.1 Place of vaccination
   - 1.2 Day and time
   - 1.3 Vaccinator (ANM) and supporting workers (ASHA and AWWs)
   - 1.4 Mode of information/ mobilisation
   - 1.5 If she does not know, check if she has migrated/newly moved in

2. **Have you or your child ever received any vaccination? If yes, please tell us in detail about the same.**
   Probe:
   - 2.1. Where
   - 2.2 When
   - 2.3 Who informed you about the vaccination
   - 2.4 What was the experience after the vaccination

3 **Did your child or you (pregnant woman) receive vaccination during the IMI period? If No, what please tell us why?**

4 **How the ANM/ASHA/AWW behave/ treat you (and/or others in your locality) and others in your neighbourhood usually (apart from the immunization session)?**
   Probe:
   - 4.1. Any mistreatment to you or any other beneficiary
   - 4.2. Any difference in treatment from others
   - 4.4. Overall satisfaction with the services

5 **Were you informed about the due immunization for yourself/ your child (during IMI period)? If yes, how?**
   Probe:
   - 5.1. Any home visit to check vaccination status
   - 5.2. Any message/ reminder for vaccination and session
   - 5.3. Any announcement system

6. **How was your opinion and experience about the immunization session organisation?**
   Probe:
   - 6.1. Place where session was organised
   - 6.2. Facilities for sitting/waiting
   - 6.3. Privacy for vaccinating pregnant women

7. **Why did not you get vaccination during the IMI vaccination days and/or session sites?**
   List all mentioned.
   Probe: 7.1. Any family practice/ opinion
   7.2. Any rumor/ other influence
   7.3. Any logistics/ travel related challenge
   7.4. Any past experience related
   7.5.
8. **Are you aware of any child/pregnant women in your locality or whom you know or who are not able to come, who don't want to come for immunization? If yes, why?**
   Probe: 8.1 Any beliefs, rituals or rumors
   8.2. Any health concerns or fear or side effects
   8.3. Any logistic/access related problem
   8.4. Any other socio-cultural reasons

9. **Quotable quotes**

**TOOL 4: CASE STUDY ON INTENSIFIED MISSION INDRADHANUSH (IMI) IN INDIA**
**DISTRICT ASSESSMENT SUMMARY REPORT**

**Name of District visited: ……**
**Name of State visited: ……..**
**Dates of Field Visit: From** …… **To …….**

1. **What worked for IMI?**
   1.1. What were the strengths of the IMI program?
   1.2. How cross-sectoral coordination worked and what more could have been done?
   1.3. Any innovation used

2. **What did not work for IMI?**
   2.1. Challenges/weaknesses of the IMI program and the potential reasons
   2.2. Any suggestion for improvement

3. **How did IMI contribute to system strengthening?**
   3.1. Impact on the program/health system (immunization and other programs)

4. **Overall Assessment of the District** (from Quality, Equity and Dignity aspect)

5. **Quotable quotes**

| Team Member 1 | Team Member 2 |
|---|---|
| Signature | Signature |
| Name | Name |
| Team Member 3 | Team Member 4 |
| Signature | Signature |
| Name | Name |