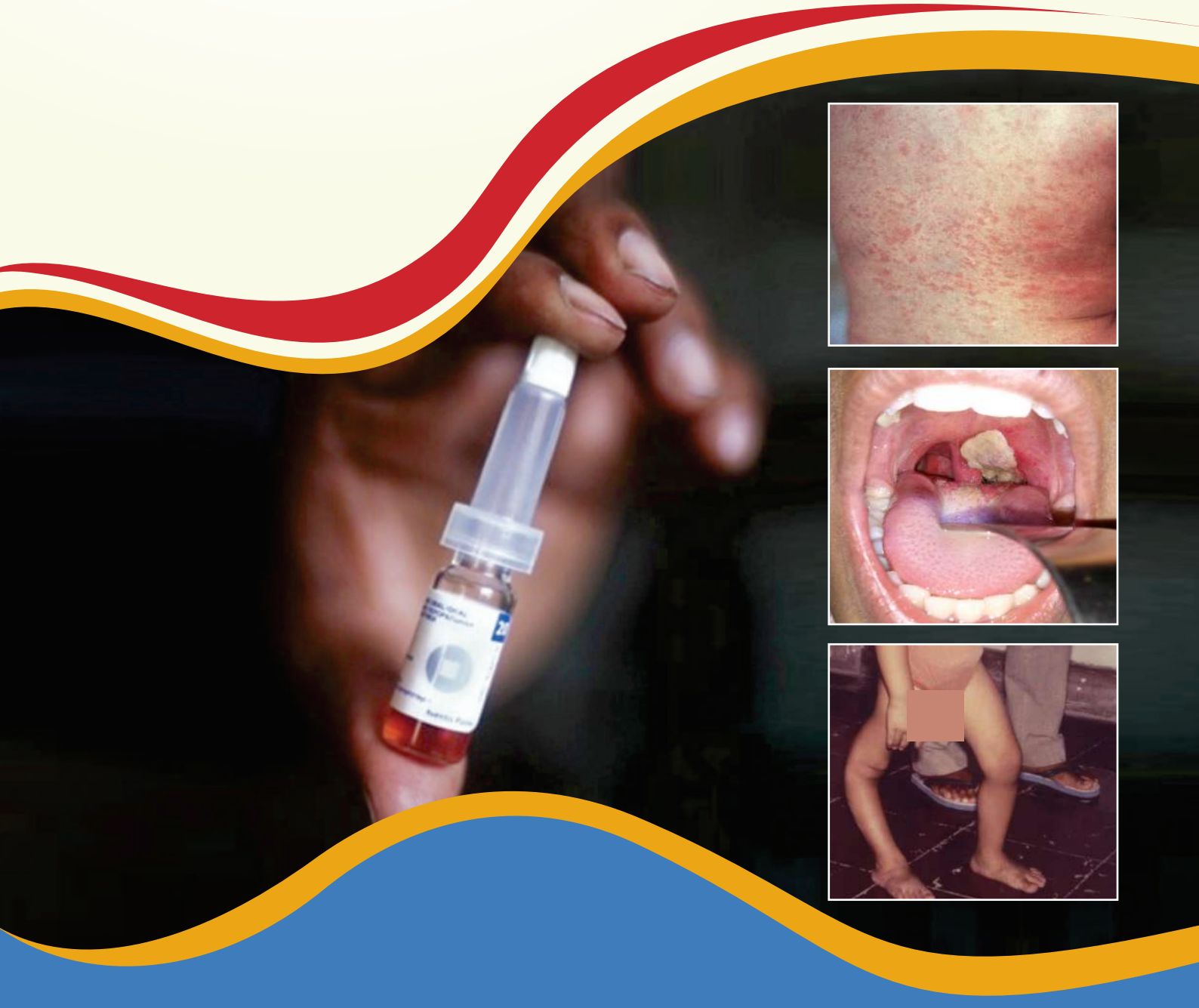
सत्यमेव जयते



Operational Guidelines for Vaccine Preventable Disease Surveillance

Integrated Disease Surveillance Programme, NCDC | Ministry of Health & Family Welfare | Government of India | 2026

Operational Guidelines for Vaccine Preventable Disease Surveillance

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जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA

सत्यमेव जयते

मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार
Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India

FOREWORD

India stands at a defining moment in its public health journey. Guided by the Hon'ble Prime Minister's vision of an *Atmanirbhar Bharat*, our health system is steadily moving towards self-reliance, resilience and excellence.

India has successfully addressed numerous public health challenges. Key milestones include achievement of polio-free status in 2014, elimination of maternal and neonatal tetanus in 2015 and most recently elimination of trachoma as a public health problem in 2024-25. These successes are the most significant public health accomplishments of our time, which reflect the unwavering commitment of our health workforce, strong community participation and a robust surveillance system.

As we advance towards the elimination of Measles and Rubella and strive to sustain the gains achieved through earlier disease surveillance initiatives, it is imperative that we continue to strengthen our surveillance systems. A responsive, integrated and high-quality surveillance framework is essential for early detection of cases, prompt public health action and prevention of outbreaks.

The Integrated Disease Surveillance Programme (IDSP) plays a pivotal role in implementing and strengthening disease surveillance activities across the country. Through its established network and mechanisms for timely reporting, investigation, analysis and response, IDSP serves as the backbone of public health surveillance and outbreak management.

These Operational Guidelines provide a clear and practical roadmap for implementing and strengthening surveillance activities across all levels of the health system. They outline the roles, responsibilities and processes necessary to ensure effective surveillance, timely reporting, thorough investigation and coordinated response. I am confident that these guidelines will serve as a valuable resource for states and districts in our collective efforts to protect every life and achieve disease elimination goals.

(Jagat Prakash Nadda)

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प्रतापराव जाधव
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व
राज्य मंत्री
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भारत सरकार
MINISTER OF STATE
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MINISTRY OF AYUSH AND
MINISTER OF STATE OF
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

FOREWORD

The Government of India is committed to strengthening public health systems and ensuring equitable healthcare for all. A resilient health system must be capable of detecting cases early, responding swiftly to outbreaks, and protecting communities, particularly in remote and underserved areas. In this context, vaccine-preventable disease (VPD) surveillance is a critical pillar of public health, enabling timely action to prevent outbreaks and safeguard lives.

India's public health achievements, including polio eradication and the elimination of maternal and neonatal tetanus, reflect the strength of our health system, sustained commitment, and effective disease surveillance mechanisms. As we progress towards the elimination of Measles and Rubella and strengthen preparedness against emerging public health events, a robust surveillance system remains fundamental to protecting public health.

The Integrated Disease Surveillance Programme (IDSP) has been instrumental in strengthening disease surveillance across the country by providing a robust framework for the timely detection, reporting, and response to public health events. Over the years, IDSP has enhanced our capacity to monitor disease trends, investigate outbreaks, and guide evidence-based public health action.

These Operational Guidelines provide a comprehensive framework for strengthening surveillance activities across all levels of the health system. They outline standardized approaches for case detection, reporting, investigation, data management, risk communication, and coordinated response. The guidelines also emphasize the importance of inter-sectoral coordination and continuous capacity building to ensure that surveillance systems remain responsive, inclusive, and effective.

Government of India under the visionary leadership of Hon'ble Prime Minister Shri Narendra Modi ji and able guidance of Hon'ble Union Minister of Health and Family Welfare, Shri Jagat Prakash Nadda ji, is committed to ensure the safety and well-being of citizens in India. I am confident that these guidelines will support states and districts in enhancing surveillance performance. Together, through robust surveillance and collective action, we can detect health events early, prevent outbreaks, safeguard public health, and move closer to our vision of a healthier and stronger India.

सर्वे भवन्तु सुखिनः। सर्वे सन्तु निरामयाः।

(Shri Prataprao Jadhav)

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पुण्य सलिला श्रीवास्तव, भा.प्र.से.
सचिव
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Secretary

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स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

India stands at a pivotal moment in its public health journey. The decades of investment in building a robust, nationally owned disease surveillance infrastructure have created the foundation for the next phase of progress. The consolidation of Vaccine-Preventable Disease (VPD) surveillance within the Integrated Disease Surveillance Programme (IDSP) is a decisive step in that direction — one that reflects the Government's commitment to strengthening India's health security through systems that are self-reliant, accountable, and driven by evidence.

The Universal Immunization Programme has been one of India's most consequential public health investments, protecting children from polio, measles, rubella, diphtheria, pertussis, and neonatal tetanus. Effective surveillance is the backbone of this programme. It enables us to identify gaps, detect outbreaks early, respond swiftly, and continuously refine our immunization strategy. The transition of VPD surveillance to IDSP must be executed with the same rigour and commitment that has characterised India's immunization successes.

These Operational Guidelines represent a comprehensive and carefully considered framework to guide States and Union Territories (UTs) through this transition. I call upon States/UTs and their leadership to lend full institutional support to this effort. The health of India's children depends on the strength of our surveillance systems, and these guidelines provide the roadmap to make them stronger.

Punya Salila

Dated 22nd May, 2026

(Punya Salila Srivastava)

#StopObesity
टीबी हारेगा देश जीतेगा / TB Harega Desh Jeetega

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स्वास्थ्य सेवा महानिदेशालय

Government of India
Ministry of Health & Family Welfare
Directorate General of Health Services

Message

The DGHS has, over the decades, provided the technical backbone of India's public health architecture. Disease surveillance is central to that mandate. Accurate, timely, and integrated surveillance data is what enables our health system to detect threats early, respond effectively, and safeguard the hard-won gains of our immunization programmes. The consolidation of VPD surveillance within IDSP is a technically sound decision that will enhance the coherence and efficiency of India's disease surveillance ecosystem.

Sustaining India's polio-free status and advancing towards measles and rubella elimination are non-negotiable goals. Both require surveillance systems that meet exacting global standards in terms of Acute Flaccid Paralysis (AFP) and suspected Measles Rubella (MR) case detection rates, % stool adequacy, case investigation rates, sample collection and shipment with laboratory linkages. These Operational Guidelines provide the technical standards and implementation mechanisms to ensure that IDSP meets and exceeds these global benchmarks. DGHS is committed to providing the technical oversight and quality assurance mechanisms necessary to support this transition at every level.

I commend the NCDC and IDSP teams for developing these Operational Guidelines and urge all States and Union Territories to treat this document as an essential reference. The protection of every child from vaccine-preventable disease is a shared responsibility, and robust surveillance is how we honour that commitment.

(Loveneesh G. Krishna)

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Dr. Rakesh Gupta, IAS
ADDITIONAL SECRETARY

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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
KARTAVYA BHAWAN-1, NEW DELHI-110001

Message

The health of a nation's children is among the most reliable indicators of its public health priorities. India's Universal Immunization Programme, one of the largest in the world, has saved millions of lives and transformed the burden of vaccine-preventable diseases. Without sensitive, timely, and high-quality surveillance, immunization policy cannot be evidence-based, coverage gaps cannot be identified, and outbreaks cannot be contained.

The Government of India has taken a considered policy decision to consolidate Vaccine-Preventable Disease (VPD) surveillance within the Integrated Disease Surveillance Programme (IDSP). The WHO-National Public Health Support Network (NPSN), a technical collaboration between the Government of India and WHO since 1997, has served its purpose with distinction. As India's own surveillance infrastructure has matured, it is both appropriate and timely that IDSP assumes the full operational mandate for VPD surveillance. This is not merely an administrative consolidation; it is a public health commitment that demands meticulous planning, sustained investment, and unwavering accountability at every level of the health system.

These Operational Guidelines provide the framework for states and Union Territories to implement this consolidation in a phased and systematic manner. They articulate the governance structures from the National Oversight Committee and Joint Working Group through to State and District Task Forces on Immunization. They lay out the resource mapping, capacity-building, and monitoring mechanisms required to ensure that surveillance sensitivity is not merely maintained but enhanced through this process.

A strong emphasis has been placed on sustaining AFP surveillance at global benchmarks, as maintaining India's polio-free status demands perpetual vigilance. Equally, the path towards measles and rubella elimination requires surveillance systems that are responsive, analytically robust, and institutionally embedded. I urge all State Health Secretaries, Mission Directors, and Surveillance Officers to treat this document as an operational priority, and to ensure that the human and financial resources committed through NHM PIPs are utilised effectively. The completion of this consolidation by March 2027 is a commitment we must collectively honour.

(Dr. Rakesh Gupta)

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अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
Aradhana Patnaik, IAS
Additional Secretary & Mission Director (NHM)

सत्यमेव जयते

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स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

MESSAGE

The National Health Mission has consistently underscored that surveillance is not a peripheral function—it is the backbone of public health action. Strong surveillance systems enable early detection, timely response, and evidence-based program decisions. As India transitions Vaccine Preventable Disease (VPD) surveillance into the Integrated Disease Surveillance Programme (IDSP), we have a critical opportunity to embed this function firmly within our routine health systems and National Health Mission (NHM) frameworks.

India's achievements—including sustaining polio-free status and advancing measles-rubella elimination—must now be reinforced through a robust, integrated, and high-performing surveillance system. This transition is therefore not just administrative; it is strategic, and it demands commitment at every level.

These Operational Guidelines clearly define what is required to make surveillance systems effective and responsive—dedicated human resources, reliable logistics and cold chain, efficient sample management, mobility for field functionaries, strong data systems, and continuous capacity building. States and districts must ensure that these essential components are fully planned, resourced, and operationalized.

I urge all States to prioritize VPD surveillance within NHM planning and budgeting processes, and to translate these requirements into well-structured proposals under the NHM flexipool. Investments in surveillance—whether for frontline worker mobility, sample transport, contractual staff, training, or digital platforms such as VSIMS—IHIP—are critical to sustaining programme outcomes and achieving global benchmarks.

Strong leadership, accountability, and timely action will determine the success of this transition. District Surveillance Officers must ensure that planned activities are implemented effectively on the ground, while State Surveillance Officers must drive performance through close monitoring and regular review. State Health Societies must ensure timely release of funds so that surveillance activities are not disrupted.

Institutional platforms such as the State and District Task Forces on Immunization (STFI/DTFI) must be actively used for continuous review, monitoring of key performance indicators, and prompt corrective action. Equally, strengthening community and private sector engagement will be essential to improve early case detection and reporting.

The timeline for full transition by March 2027 is firm, and the time to act is now. I urge States and districts to approach this with urgency, ownership, and a results-oriented mindset—prioritizing planning, capacity building, system integration, and field-level implementation. By strengthening surveillance today, we are securing not only past achievements but also building a resilient and future-ready public health system for India. Let us work together to ensure surveillance that is timely, sensitive, and action-driven across every district.

Dated: 19th May, 2026

(Aradhana Patnaik)

#StopObesity
टीबी हारेगा देश जीतेगा / TB Harega Desh Jeetega

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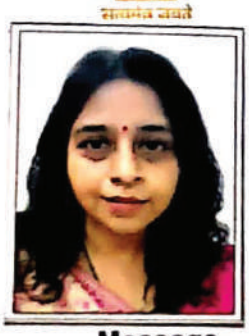
Meera Srivastava, IRS
Joint Secretary



भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

India's Universal Immunisation Programme is one of the largest public health efforts in the world, yet vaccination alone does not guarantee protection. A vaccine delivered without knowing whether disease is circulating, where vulnerable pockets remain, or whether immunity gaps are widening is an intervention without direction. Surveillance is what gives immunisation its strategic compass and these Operational Guidelines represent an important step in aligning our surveillance system with the real-time information needs of the immunisation programme.

The relationship between surveillance and immunisation is not one-directional. Surveillance data drives immunisation decisions, identifying low-coverage districts, flagging outbreak-prone geographies, and validating whether elimination targets are within reach while the immunisation programme, in turn, shapes the epidemiology that surveillance must track. At every level, the value of this integration depends on how consistently the two functions coordinate; a District Immunisation Officer reviewing coverage without reference to local notification rates, and a District Surveillance Officer tracking cases without knowing the immunisation profile of the affected area, are each working with an incomplete picture.

A VPD surveillance system must be sensitive enough to detect residual transmission, disaggregated enough to identify where coverage has not translated into protection, and integrated enough that a drop in detection rates triggers an immunisation response, not just a surveillance correction. States where Surveillance and Immunisation Officers review data together, map outbreak clusters against microplan coverage, and jointly design catch-up responses will be the ones that meet their elimination targets.

Across all six vaccine-preventable diseases covered here, the success of the immunisation programme, its ability to target, respond, and demonstrate impact rests on the quality of surveillance feeding into it. I urge State and District Immunisation and Surveillance Officers to treat these guidelines as a shared mandate. The surveillance system and the immunisation programme serve the same child; the stronger their coordination at every level, the closer India gets to the disease-free future both are working toward.

#Measles Rubella Elimination

(Ms. Meera Srivastava)

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Joint Secretary

सत्यमेव जयते

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Message

The integration of VPD surveillance into IDSP is an important step in strengthening India's public health infrastructure. For too long, surveillance functions have operated across parallel systems, limiting the potential for integrated analysis, coordinated response, and unified accountability. The consolidation of VPD surveillance within IDSP creates the conditions for a truly integrated national surveillance platform - one where data flows seamlessly, response mechanisms are coordinated, and the burden on frontline health workers is rationalised.

These Operational Guidelines provide a practical, phased framework for implementation. The governance architecture - from the National Oversight Committee to State and District Task Forces on Immunization - provides clear accountability at every level. The resource mapping, training frameworks, and monitoring mechanisms outlined in this document are designed to ensure that the transition strengthens the existing surveillance capabilities. Particular attention must be paid to the reporting units and informer networks, especially private sector engagement mechanisms that form the community-level foundation of effective VPD surveillance.

I urge state and district officials to engage with these guidelines in a spirit of active ownership. The success of this consolidation depends not merely on policy directives from the national level, but on the commitment and initiative of programme managers at every tier. I am confident that with the right effort and institutional support, the integration of VPD surveillance into IDSP will significantly enhance India's capacity to protect its children from vaccine-preventable diseases.

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Foreword

India's journey in controlling Vaccine Preventable Disease (VPD) stands as a testament to the collective resolve of our public health system. The declaration of polio-free status by the WHO South-East Asia Region in 2014 confirmed that when science, systems, and community engagement work in concert, even the most formidable public health challenges can be overcome. That achievement must now be protected and built upon.

The National Centre for Disease Control (NCDC), as the apex institution for disease surveillance in India, has long championed a unified, self-reliant national surveillance framework. The integration of VPD surveillance within IDSP represents one of the most significant structural advances in India's public health surveillance system in recent years, reflecting our commitment to Aatm-Nirbharta in health security.

These Operational Guidelines provide a comprehensive, actionable roadmap for state and district health officials, addressing case detection, laboratory linkages, data management through VSIMS and IDSP-IHIP, outbreak investigation, and accountability frameworks across the six priority VPDs: Polio, Measles, Rubella, Diphtheria, Pertussis, and Neonatal Tetanus.

Capacity building is a critical pillar of this consolidation. The IDSP network at national, state, and district levels must be equipped not only with technical skills in surveillance methodology, but also with the institutional confidence to sustain surveillance quality to global standards. NCDC will continue to provide technical leadership through training, mentorship, and quality assurance. I commend all those who have contributed to these guidelines and urge every stakeholder to use this document as an active operational reference in the service of a healthier India.

12/5/26

Dated 12th May, 2026

Prof. (Dr.) Ranjan Das

Dr. Pawan Kumar
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Foreword

India's Universal Immunization Programme (UIP) is one of the world's largest public health initiatives, reaching crores of infants, children, and pregnant women each year through a vast delivery network that includes fixed facilities, outreach sessions, and community-based interventions. Ensuring the effectiveness, equity and impact of such a programme, requires not only high vaccination coverage, but also robust, sensitive, and timely disease surveillance systems that can generate actionable evidence.

Immunization and vaccine-preventable disease (VPD) surveillance are inherently interdependent. Immunization reduces disease burden, while surveillance provides the metrics to validate programme performance, identify immunity gaps, and trigger corrective action. The transition of VPD surveillance into the Integrated Disease Surveillance Programme (IDSP) provides a critical opportunity to institutionalize this bi-directional linkage within a unified public health framework.

At the operational level, State and District Immunization Officers are expected to proactively engage with surveillance data as part of routine immunization programme monitoring. This includes analyzing surveillance trends, participating in case and outbreak investigations, prioritizing high-risk and underperforming areas, and ensuring corrective actions are implemented through both service delivery and community engagement strategies.

The guidelines also emphasize the importance of system enablers, including trained human resources, functional sample collection and transport systems, cold chain reliability, and continuous capacity building of frontline workers (ANMs, ASHAs, CHOs). Strengthening reporting networks, including private providers and community informants will be essential to improve sensitivity and completeness of surveillance.

India's achievements in sustaining polio eradication and progressing toward measles-rubella elimination demonstrate the value of strong immunization–surveillance synergy. As surveillance transitions institutionally to IDSP, it is essential that programme managers maintain a unified operational approach, where immunization planning, implementation, and monitoring are continuously informed by surveillance evidence.

I urge all immunization programme managers at state and district levels to adopt these guidelines as a core operational reference, and to ensure that surveillance and immunization systems function in close coordination. This integrated approach will be critical to sustaining past achievements, closing immunity gaps, and achieving national and global disease elimination targets.

(Dr Pawan Kumar)

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Preface

India's Integrated Disease Surveillance Programme (IDSP) was established to create a decentralised, state-based surveillance system capable of detecting and responding to disease outbreaks rapidly and effectively. Over two decades, IDSP has evolved into a robust national platform encompassing the Integrated Health Information Platform (IHIP), a nationwide network of State and District Surveillance Units, and a reporting architecture spanning government facilities, private practitioners, and community-level informers. These Operational Guidelines serve as the practical handbook for state and district health officials, drawing on programme experience from IDSP, NCDC, and the Immunization Division, MoHFW, to ensure guidance that is technically rigorous, contextually grounded, and operationally feasible.

The guidelines address six vaccine-preventable diseases — Acute Flaccid Paralysis/Polio, Measles, Rubella, Diphtheria, Pertussis, and Neonatal Tetanus — with standardised case definitions, sample collection protocols, laboratory linkages, and reporting timelines for each. Detailed guidance is provided on maintaining global benchmarks for non-polio AFP rate and stool adequacy, reflecting India's non-negotiable commitment to sustaining its polio-free status, with equal rigour applied to measles and rubella elimination goals.

The VSIMS portal is detailed extensively, including workflows, reporting timelines, integration pathways with IDSP-IHIP, Standard Operating Procedures for AFP and Measles-Rubella record-keeping, a performance monitoring framework covering surveillance indicators and targets, and a risk register and mitigation strategies to guide states through the transition.

The integration of VPD surveillance within IDSP affirms India's domestic capacity to own, operate, and continuously strengthen its disease surveillance systems. I place on record my appreciation for the sustained collaboration between IDSP, NCDC, and the Immunization Division at all levels. These guidelines are offered as a technical instrument in the hands of committed public health professionals who will ensure that India's children remain protected from vaccine-preventable diseases, today and for generations to come.

Dated 12th May, 2026

(Dr. Himanshu Chauhan)

ACKNOWLEDGEMENTS

The development of these Operational Guidelines for Integration of VPD Surveillance through Strengthening of IDSP has been a collaborative endeavour, drawing upon the knowledge, experience, and commitment of individuals and institutions across India's public health system. The Ministry of Health & Family Welfare, Government of India, gratefully acknowledges the contributions of all those who have made this document possible.

Leadership and Institutional Guidance

These guidelines were developed under the overall guidance and leadership of the Ministry of Health & Family Welfare, Government of India. The support and direction provided by the Additional Secretary (Public Health) and the Additional Secretary & Mission Director, NHM, were instrumental in shaping the policy framework and programmatic priorities reflected in this document. The Director, National Centre for Disease Control (NCDC), provided the institutional leadership under which this work was carried out.

Technical Development and Authorship

These Operational Guidelines were primarily developed by the IDSP team at NCDC, under the stewardship of the Additional Director & National Programme Officer, IDSP. The document was reviewed and finalised in close collaboration with the Immunization Division, MoHFW, whose inputs were essential in aligning VPD surveillance standards with the programmatic framework of the Universal Immunization Programme.

The technical inputs of the Joint Working Group constituted under the National Oversight Committee for VPD Surveillance Transition were indispensable. Members of the Joint Working Group, drawn from NCDC, the Immunization Division, and state surveillance programmes, brought the depth of field experience and technical rigour that makes these guidelines operationally credible and nationally relevant.

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State Contributions

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We recognise that the strength of any operational guideline ultimately lies in its implementation. It is the dedication of thousands of health workers - Surveillance Medical Officers (SMO), District Surveillance Officers (DSO), Auxiliary Nurse Midwife (ANM), Accredited Social Health Activists (ASHAs) laboratory technicians, and data entry operators - across India who will bring these guidelines to life. It is to them, and to the communities they serve, that this work is dedicated.

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LIST OF ABBREVIATIONS

Abbreviation	Full Form
AAM	Ayushman Arogya Mandir
ACS	Active Case Search
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
CEA	Clinical Establishments (Registration and Regulation) Act
CHC	Community Health Centre
CHO	Community Health Officer
CIF	Case Investigation Form
CSU	Central Surveillance Unit
VDPV	Circulating Vaccine-Derived Poliovirus
DGHS	Directorate General of Health Services
DHAP	District Health Action Plan
DIO	District Immunization Officer
DSO	District Surveillance Officer
DTH	Diphtheria
DTFI	District Task Force for Immunization
DWR	District Weekly Review
EPID	Epidemic Identification Number
ERC	Expert Review Committee
ES	Environmental Surveillance
eVIN	Electronic Vaccine Intelligence Network
FC	Field Coordinator
fIPV	Fractional Inactivated Polio Vaccine
GBS	Guillain-Barré Syndrome
GPEI	Global Polio Eradication Initiative
HP	High Priority
HR	Human Resources
HRA	High Risk Area
IDSP	Integrated Disease Surveillance Programme
IEAG	India Expert Advisory Group (Polio & MR)

Abbreviation	Full Form
IHIP	Integrated Health Information Platform
IPV	Inactivated Polio Vaccine
IUs	Informer Units
IVIG	Intravenous Immunoglobulins
iVDPV	Immunodeficiency-related Vaccine-Derived Poliovirus
KPIs	Key Performance Indicators
LHV	Lady Health Visitor
LP	Low Priority
LRF	Lab Request Form
M&E	Monitoring and Evaluation
MOB	Measles Outbreak
MoHFW	Ministry of Health & Family Welfare
MO	Medical Officer
MOIC	Medical Officer In-Charge
MR	Measles Rubella
NCCPE	National Certification Committee for Polio Eradication
NCDC	National Centre for Disease Control
NHM	National Health Mission
NIV	National Institute of Virology
NMNR	Non-Measles Non-Rubella
NNT	Neonatal Tetanus
NPAFP	Non-Polio Acute Flaccid Paralysis
NPEV	Non-Polio Enteroviruses
NPSN	National Public Health Support Network
NPSP	National Polio Surveillance Project
NTAGI	National Technical Advisory Group on Immunization
NVC MR	National Verification Committee for Measles and Rubella
OB	Outbreak
OPV	Oral Polio Vaccine
ORI	Outbreak Response Immunization
PCR	Polymerase Chain Reaction
PHC	Primary Health Centre
PID	Primary Immunodeficiency
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PTS	Pertussis

Abbreviation	Full Form
RCH	Reproductive and Child Health
RI	Routine Immunization
RoHFW	Regional Office of Health and Family Welfare
RRT	Rapid Response Team
RUs	Reporting Units
SAP	State Action Plan
SEARO	South-East Asia Regional Office
SIA	Supplementary Immunization Activity
SMO	Surveillance Medical Officer
SOPs	Standard Operating Procedures
SSO	State Surveillance Officer
SSU	State Surveillance Unit
STFI	State Task Force for Immunization
TA/DA	Travelling Allowance/Daily Allowance
UIP	Universal Immunization Programme
UT	Union Territory
VDPV	Vaccine-Derived Poliovirus
VHP	Very High Priority
Vit-A	Vitamin A
VPD	Vaccine Preventable Disease
VSIMS	Vaccine-Preventable Diseases Surveillance Information Management System
VTM	Viral Transport Medium
WHO	World Health Organization
WJCF	William J. Clinton Foundation
WPV	Wild Poliovirus

CASE DEFINITIONS FOR VACCINE PREVENTABLE DISEASE*

a. **Polio (Acute Flaccid Paralysis – AFP)** - Sudden onset of weakness and floppiness in any part of the body in a child <15 year of age or paralysis in a person of any age in whom polio is suspected.

b. **Measles (suspected)** - Any person with fever and maculopapular (non-vesicular) rash or any person in whom a health worker or clinician suspects measles infection.

c. **Rubella (suspected)** - Any person with fever and maculopapular (non-vesicular) rash, or any person in whom a health worker or clinician suspects rubella infection.

d. **Diphtheria (suspected)** - Any illness of Upper Respiratory Tract, characterized by laryngitis or nasopharyngitis or pharyngitis, or tonsillitis and an adherent membrane on tonsils, pharynx, and/or nose.

e. **Pertussis /Whooping Cough (suspected)** - A person of any age with a cough lasting ≥2 weeks or of any duration in an infant or any person in an outbreak setting, without a more likely diagnosis, AND with at least one of the symptoms on observation or parental report: a) Paroxysms (i.e fits) of coughing, b) Inspiratory whooping, c) post-tussive vomiting, or vomiting withouth apparent cause d) apnoea in infants (<1 year of age); OR clinician suspicion of pertussis.

f. **Neonatal Tetanus (NNT)(suspected)** - Any neonate who could suck and cry normally during the first two days of life and who cannot suck normally between 3 and 28 days of age, and becomes stiff or has convulsions/spasms, i.e. jerking of the muscles or both; or any neonate who dies of an unknown cause during the first month of life.

Table 1: *VPDs Sample Collection Guide*

S. No.	Suspected Condition	Type of Sample	Number of Sample(s)	Recommended Time Period for Collection
1.	Acute Flaccid Paralysis	Stool	2 (at least 24 hours apart)	Within 14 days of onset of paralysis (up to 60 days of onset)
2.	Measles/ Rubella	Serum	1	Within 28 days of onset of rash
		Throat swab/Nasopharyngeal swab/ Urine (in order of preference)	1	Within 07 days of onset of rash
3.	Diphtheria	Throat Swab or pieces of membrane (in Amies Transport Media)	2	Within 04 weeks (of date of onset of sore throat)
4.	Pertussis	Nasopharyngeal swab (in Amies transport media with charcoal)	2	Within 04 weeks (of date of onset of cough)
		Serum	1	Within 12 weeks (of date of onset of cough)
5.	Neonatal Tetanus	No specimen required (clinical diagnosis)		

***Source:** VPD Guidelines, MoHFW

EXECUTIVE SUMMARY

India has achieved significant milestones in controlling and eliminating vaccine-preventable diseases (VPDs), including sustaining a polio-free status since 2014. To consolidate these gains and align with global standards, the Government of India is transitioning VPD surveillance from WHO-supported National Public Health Support Network (NPSN) to the Integrated Disease Surveillance Programme (IDSP). States/UTs already have a good and efficient disease surveillance mechanism. This operational guideline provides a roadmap for state and district health officials to ensure a smooth, phased, and effective transition of VPD surveillance to IDSP by 2026–27.

The primary objectives are to ensure continued, high-quality VPD surveillance, across the States/UTs and districts for timely detection, reporting, investigation, and to sustain Acute Flaccid Paralysis (AFP) surveillance at global benchmarks, to aim for MR elimination, and to generate reliable evidence to guide the immunization programme. The guidelines also aim to strengthen collaboration between general health services, immunization programmes, and private/informal health care providers.

The scope of these guidelines focuses on six priority VPDs - Polio, Measles, Rubella, Diphtheria, Pertussis, and Neonatal Tetanus - and outlines standardized approaches for case detection, investigation, laboratory support, data management, outbreak response, and monitoring. Oversight is structured at multiple levels: an Oversight Committee and Joint Working Group at the National level, restructured State Task Force for Immunization (STFI) with inclusion of the State Surveillance Officer under IDSP and strengthened District Task Force for Immunization (DTFI) with the District Surveillance Officer as a core member.

Key components of integration include coordinated state action plans, the capacity building exercise to be actively taken, integration of surveillance information systems (VSIMS with IDSP-IHIP), active engagement of private providers, informal reporting networks, and existing NPSN units. This document will guide the states to continue to keep the Surveillance standards at par with the global performance benchmarks monitored through STFI and DTFI reviews.

The quality of surveillance including reporting, data inconsistencies, adherence to laboratory timelines will be addressed through intensive training, supervision & digital integration.

India has an efficient inbuilt Disease Surveillance Mechanism and the complete transition of VPD surveillance to IDSP-NCDC will be completed by March 2027. This transition of VPD surveillance system embedded within IDSP will continue to adhere to the global standards of sensitivity and timeliness, strengthening district and state capacities for outbreak detection and response, and providing robust evidence to inform immunization and public health policies.

VACCINE PREVENTABLE DISEASE

1. Introduction

India's VPD surveillance strategy reflects a well-integrated model where global standards (WHO, GPEI) are localized through robust lab networks, field protocols, data systems (IDSP-IHIP/VSIMS), and programs enhancing immunization logistics (UIP, eVIN). This ensures comprehensive detection, investigation, and response for Vaccine Preventable Diseases.

The National Polio Surveillance Project (NPSP) was launched in 1997 by WHO in collaboration with the Government of India. Its primary mandate was to support polio eradication through active surveillance, focusing heavily on Acute Flaccid Paralysis (AFP) detection and data analysis. Following the achievement of polio-free status in India (last wild polio virus case in 2011, South-East Asia certified polio-free in 2014), NPSP evolved into the National Public Health Support Network (NPSN), broadening its support to routine and special immunization efforts and surveillance of Vaccine-Preventable Diseases (VPDs), including Polio, Measles, Rubella, Diphtheria, Pertussis, and Neonatal Tetanus.

The Government of India (GOI) leads implementation and policy direction and is committed to integrate this initiative into public health systems through complete self-reliance (AtmaNirbharta). With an existing disease surveillance programme in place and the simultaneous phasing out of NPSN units by March 2027, VPD surveillance will be transitioned to IDSP. These operational guidelines provide the necessary guidance for VPD surveillance activities while maintaining high-quality global standards.

2. Objectives

- To ensure a seamless transition of VPD surveillance activities to IDSP at state and district level.
- To strengthen the state health system at all levels for implementation of VPD surveillance activities.
- To ensure the use of VSIMS as a uniform VPD reporting and data management system by all States/ UTs and district surveillance units.
- To ensure that the quality, sensitivity, and timeliness of VPD surveillance is maintained at par with global benchmarks throughout and after transition, sustaining India's polio-free status.

3. Scope

The scope of the current operational guidelines is limited to activities pertaining to VPD surveillance through strengthening of general health services by the States and IDSP in particular for its effective monitoring. The immunization related activities – both routine & special, will continue to be handled by the immunization/ RCH officials at State & District levels.
These guidelines apply to the VPD surveillance activities currently for six diseases *(Polio, Measles, Rubella, Diphtheria, Pertussis & Neonatal Tetanus)*. The key activities include:

- Case detection & reporting
- Case investigation
- Sample collection, storage & shipment
- Laboratory support
- Data management and ensuring data quality
- Capacity building
- Outbreak investigations
- Monitoring & evaluation
- Maintaining Reporting Network
- Follow up and final classification of cases and Outbreaks

4. Framework for Strengthening and Integration

4.1 National Level*

- **An Oversight Committee**

  To monitor the progress of transition of VPD surveillance activities and to assess the readiness of the system.

- **A Joint Working Group (JWG)**

  A Joint Working Group has been constituted to discuss the details and modalities for the transition plan.

4.2 State & District Level

- **State Task Force for Immunization**

  The present State Task Force for Immunization needs to be restructured in view of the expanded mandate of IDSP with respect to VPD surveillance activities. The IDSP SSO should be a member of the task force, and the State Immunization Officer would continue to be the member secretary. VPD Surveillance should be given priority in the review.

- **District Task Force for Immunization**

  The present District Task Force for Immunization also needs to be restructured. The IDSP DSO should be a member of the task force and the District Immunization Officer would continue to be the member secretary.

** Order Letters attached as Annexure I*

5. Key Components of Integration of VPD Surveillance

5.1 Strengthen Interaction and Coordination with States/UTs

- Visits by designated GoI Nodal Officers of the States (from NCDC & RoHFW) to sensitize the State Health leadership.
- Review of district wise disease burden and performance indicators for each VPD.
- Development of State Action Plan for integration of VPD surveillance with IDSP, in sync with the phased transition approved by GoI

5.2 Capacity Building and Training

- Capacity building through structured training and workshops is a critical component of VPD surveillance. The objective of capacity building is to strengthen knowledge and skills of health personnel in VPD case detection, notification, reporting, and investigation. The suggested training plan is given in *Table 2*

Table 2: *Training and Capacity Building Activities to be Organized at Various Levels*

Level	Target Participants	Key Topics	Frequency*	Duration*
State	District surveillance officer, District epidemiologists, District data manager, District data entry operator, District microbiologist	• VPD case detection, notification & investigation • Sample collection & transportation • Outbreak protocols • Active case search • Reporting (Weekly reports and VSIMS)	At least once a year	2 days
District	Block level medical officers, Nodal officers, Lab technician, Data entry operators and other relevant cadres	• VPD case detection, notification & investigation • Sample collection & transportation • Outbreak protocols • Active case search • Reporting (Weekly reports and VSIMS)	At least once a year	1 day
Block	Medical officers, Lab technician, CHOs, LHVs, ANMs, ASHA facilitators, ASHAs, representatives from reporting network	• VPD case detection, notification & investigation • VPD case detection, notification & investigation • Sample collection & transportation • Outbreak protocols • Weekly reporting	At least once a year	0.5 day

Level	Target Participants	Key Topics	Frequency*	Duration*
Medical Colleges	Facility nodal officer, department faculty, residents and staff nurses from relevant departments**	• Case definition • CIF filling • Sample collection • Weekly reporting	Every 6 months (aligned with resident turnover)	0.5 day
Private Reporting sites	Private practitioners, nursing home/hospitals	• VPD case definition • Mandatory notification • Sample collection • Contact points for reporting	At least once a year	0.5 day

* *The frequency and duration of trainings mentioned above are indicative. These may be modified as per local needs and context.*

** *Relevant departments include Paediatrics, Dermatology, Neurology, Medicine, ENT, Physiotherapy, Emergency*

5.3 Reporting Format and Data Management

- Use of VSIMS module by designated nodal officers (IDSP) at the district level.
- Modify the IDSP module of Integrated Health Information Platform (IHIP) to incorporate additional components from VSIMS.
- Promote the use of the Community Reporting Tool of IDSP-IHIP for case detection (by private providers, quacks, faith healers & other non-Govt. entities).
- Comply with the mandatory documentation & reporting requirements at state & district levels w.r.t VPD surveillance including weekly zero reporting.

5.4 Strengthening and Reorientation of Reporting Network

- Onboarding of the existing VPD reporting network (Medical colleges, private practitioners etc.) to IDSP-IHIP, where applicable.
- Expand surveillance efforts to under-reporting areas by including religious sites and other health establishments. Expansion of reporting sites should be based on health seeking behaviour of the community.
- Expand the use of community reporting tool for VPD surveillance especially case notification without compromising the quality of VPD surveillance.
- Ensure Active Case Search for any new or missed cases of VPDs at the reporting sites.

5.5 Gradual Reduction in WHO-NPSN Units

- Integration of VPD surveillance activities into the integrated disease surveillance system in accordance with the directions of MoHFW, GoI and as per the prescribed timelines.
- Redistribute existing resources to high-priority regions while ensuring uninterrupted surveillance coverage.
- Complete transitioning of all VPD surveillance activities from WHO-NPSN to IDSP and complete data record on VSIMS portal by 2027.

5.6 Accountability and Performance Monitoring

- VPDs are governed by the international benchmarks for VPD specific indicators. These benchmarks are monitored at Global, Regional, National, State & District level. These indicators have to be kept at par or above the Global benchmarks.
- State IDSP unit shall monitor VPD surveillance activities to ensure that performance continues to meet global standards VPD surveillance indicators shall be reviewed during the meetings, and urgent corrective measures shall be undertaken on priority.
- Continue to implement the existing performance monitoring framework at state & district level with measurable output indicators.
- The health care functionaries should perform the suggested roles and responsibilities at all levels w.r.t. VPD surveillance*.

6. Implementation Framework for VPD Surveillance

Effective implementation of VPD surveillance requires a structured and coordinated approach across all levels of the health system. The following framework outlines the key operational components that must be addressed to ensure surveillance activities are functional, sustained, and responsive:

6.1 Mapping of Resources

- Human Resource – Identification of human resource at all levels (State/District/ Block/Taluka/Ward/PHC/AAM) for VPD surveillance activities including detection, investigation, sample collection, transportation.
- Reporting Sites - Reporting Units to be mapped with the districts, and informer units to be mapped with the blocks for effective VPD surveillance activities.
- Logistics - Cold chain equipment, sample collection kits and consumables. Stationery (CIFs, LRFs, weekly reporting formats and registers for peripheral units).
- Sample transport – courier agency, messenger.
- Mobility – For VPD Surveillance activities including sensitization, meetings/ workshops, case investigations, active case search, outbreak investigations, supportive supervision, etc.
- IEC materials – For community-level VPD awareness, utilize existing health systems channels to disseminate information and improve community engagement.
- Budget – Planning of appropriate budget for VPD surveillance activities.

6.2 Suggested Activities for Addressing Gaps

6.2.1 Human Resource

- To fill up all existing vacant positions under IDSP by States/Districts on priority basis (through NHM PIP).
- States may consider creating dedicated VPD Surveillance units at SSU and DSU levels, as per the requirements (through NHM/ State).
- Projection of additional HR such as Field Monitors (FM), if required (after assessment by the district and state task force through NHM/ State).

**Annexure II.*

6.2.2 Reporting Sites

- AFP surveillance at the local level is institution based through a comprehensive network of reporting sites which includes reporting units and informers. By ensuring reporting of all VPD cases from the above sources, the DSO aims to capture all VPD cases occurring in the geographical area.
- A list of all VPD Surveillance Reporting Sites in the district should be prepared to assess the geographic completeness and representativeness of various health systems in the reporting network.
- Spot map showing location of RUs and Informers, timeliness and completeness of reporting from RUs, prioritization of RS are few of the surveillance activities related to reporting site network.
- Performance of reporting sites should be checked regularly from VSIMS and RS not reporting / missing cases should be visited and re-sensitized.
- Silent reporting units that have potential for reporting AFP cases must be revisited and re-sensitized.

6.2.3 Logistics

- Support required for field activities (sample collection, shipment and transportation) to continue as per the existing system.
- The identified stool/ sample carriers and cold storage (used for stool/ sample transport) being common resources with immunization division, to be shared with the District/ State IDSP Unit for day-to-day activities.
- Sample carrier and cold storage equipment should be maintained separately from those used for vaccine transport and storage.
- The immunization division will facilitate the repair and maintenance of this equipment.

6.2.4 Sample Transport

- The specimens should be sent to the designated laboratories in proper cold chain in the desired temperature of 2 to 8°C.
- Timely and appropriate transport of collected samples is a critical component of effective VPD surveillance. Samples must be dispatched to designated laboratories within stipulated timelines to ensure validity of test results and prompt outbreak response.
- For AFP, plan for the specimens to arrive at the laboratory within 72 hours of dispatch. If this is not possible, the specimens must be frozen (at minus 20°C) and then shipped frozen, preferably with dry ice or with ice packs that have also been frozen at minus 20°C.
- For transporting specimens, a separate stool shipment carrier should be used and labeled 'For Stool Specimen Shipment'.
- Complete the laboratory request form (LRF) for each case. EPID number of the case

should be recorded on the label of the specimen collection container and the LRF. Data entry should be done carefully ensuring that the data entered in the CIF, LRF and the specimen container match.

- Various modes of sample transport are utilized depending on availability and geographic accessibility, including courier agencies, dedicated messengers, and government transport mechanisms.
- States are required to maintain a reliable sample transport network, with clear accountability at each level, to prevent delays, ensure cold chain integrity where required, and maintain the overall quality and sensitivity of the surveillance system.

6.2.5 Mobility

- Adequate mobility is essential for the effective implementation of VPD surveillance activities at all levels. Surveillance officers and health functionaries require reliable transport to carry out a wide range of field activities including sensitization of reporting units, conduct of meetings and workshops, case investigations, active case search, and outbreak investigations.
- Timely access to vehicles or travel reimbursement mechanisms ensures that supportive supervision visits to district and peripheral health facilities are conducted regularly and without disruption.
- States must therefore ensure that dedicated mobility support is provisioned and operationalized for surveillance teams, so that no critical activity is delayed or compromised due to logistical constraints.

6.2.6 Community Engagement & IEC measures

- Retain IEC strategies for community-level VPD awareness.
- Utilize existing health systems channels to disseminate information and improve community engagement.
- Mass media campaign to popularise the community reporting tool of IDSP for VPD surveillance activities.
- Engagement of teachers, community leaders, and religious institutions for early case detection.

6.2.7 Budget & Accountability Framework

- States to submit proposals under NHM flexipool in State PIP for getting approval of a dedicated budget for VPD Surveillance activities. *(Table 3).*
- District Surveillance Officer (DSO) - Ensure activities budgeted in DHAP are implemented, monitored, and reported.
- State Surveillance Officer (SSO) - Consolidate district plans, monitor fund utilization, report to STFI.
- State Health Society - Ensure timely release of NHM funds to districts for VPD surveillance activities.
- National Health Mission (NHM) - Monitor state-level progress via PIP reviews, mid-term appraisals, and quarterly reports.

Table 3: *Utilisation of Budget under NHM Flexipool for Proposed VPD Surveillance Activities*

S. No.	Activities/ Items Requiring Budget under IDSP
1.	**Surveillance & Outbreak Investigation**
	Mobility support for surveillance staff MOs, DSOs, ANMs, ASHAs, Field Monitors (FM) for Field visits, case investigation, active case search, follow-up visits, zero reporting verification
	TA/DA for case investigation and outbreak visits
2.	**Sample Management**
	Sample collection kits (stool containers, swabs, VTM, vacutainers, gloves, disinfectants)
	Arrange for Cold chain logistics at district and state level (Deep freezer, Refrigerator, carriers, ice packs, temperature loggers)
	Sample collection and transport of specimens (per diem to staff collecting the sample, courier services' expenses, fuel reimbursement for health workers, emergency shipment support)
	Lab request forms
	Packaging material (triple packaging), labels, barcodes
3.	**Human Resource Recruitment (contractual) & Capacity Building**
	Remuneration of Contractual HR like Field Monitors (FM) in surveillance team
	Training & capacity building: printing of training modules, venue costs, travel
	Regular Review meetings (DTFI, STFI)
4.	**Data & Reporting**
	Printing /distribution of stationery for surveillance (CIFs, and other reporting forms/ formats, record keeping registers, log book, Surveillance poster etc for VPD activities)
	VSIMS data management: Internet/ Data recharge, device support for DSOs/ SSO- IDSP
	Dashboard/reporting tool maintenance
5.	**Monitoring & Evaluation by District and State Officers** - Supportive Supervision visits, evaluation studies, national/state/district/block level reviews
	Periodic evaluations, independent assessments
	Supportive supervision visits by district/state officers
	Annual state/ national joint review meetings
6.	**IEC** - Specific prototypes for RU/Informer Units/Risk perception for general public community

7. Potential Risks and Mitigation Strategies

The transition of VPD surveillance from WHO-NPSN to IDSP involves structural, operational, and capacity-related challenges that must be anticipated and actively managed. The key risks associated with this transition and suggested mitigation strategies to be implemented at the national, state, and district levels are given in *Table 4*.

Table 4: *Potential Risks and Mitigation Strategies*

S. No.	Risks	Suggested Mitigation Strategies
1.	Drop in IDSP reporting parameters	Ensure continuous capacity building and supportive supervision Strengthen IDSP at all levels – filling up of vacant positions and strong monitoring for reporting of data at all levels
2.	Drop in AFP/ MR surveillance sensitivity	Intensive training & close monitoring by IDSP utilising the existing WHO-NPSN structure as available in the State/UT for the same as per the transition timelines
3.	Data inconsistency with regards to the reporting parameters	Intensive Desk Review and Supervision by state health department
4.	Laboratory turnaround time delays	Continued lab linkages with designated VPD laboratories shall be maintained*, with strict adherence to Standard Operating Procedures (SOPs) for specimen transport and processing, along with the provision of necessary financial support
5.	Reduced reporting from informer/ Reporting units	Sensitisation, recognition, and exploring incentives
6.	Training & motivation of existing workforce	Clear communication and recognition of contributions

8. Performance Monitoring

8.1 Monitoring and Evaluation

- Monthly review meetings to be conducted at District and State (DTFI/STFI) with dedicated agenda on VPD surveillance.
- Monitor Key Performance Indicators (KPIs) for all VPDs – case detection rates, sample adequacy rates, reporting timelines etc.
- State and District IDSP units shall monitor all VPD surveillance indicators on VSIMS on a regular basis. (ref. Section 16)
- Regularly undertake Active Case Search (ACS) to identify missed cases and to sensitize the reporting network by prioritizing visits to Very High Priority (VHP) and High Priority (HP) reporting sites.

**List of VPD Labs attached as Annexure III*

- District Weekly Review (DWR) meetings to be convened by DIO/ DSO for review of KPIs*.
- Independent Evaluation - Third-party evaluation to be undertaken in consultation with the National and State authorities to assess transition success, data quality, and identify areas for improvement.

8.2 Review Mechanism

- Joint review meetings and field visits by National and State teams shall be conducted to review the VPD surveillance programme, assess adherence to protocols, and identify areas requiring strengthening.
- State-level review meetings shall assess overall surveillance performance, training coverage, reporting completeness, and laboratory turnaround time against the targets in the monitoring framework.
- District Task Force for Immunization (DTFI) and State Task Force for Immunization (STFI) shall review the VPD Surveillance indicators during their review meetings. Corrective action to be initiated for any indicator falling below the prescribed benchmark.

9. Sustainability Measures

- States shall continue to submit VPD surveillance budget proposals under NHM Flexipool in the State PIP, covering mobility support, sample management, capacity building, HR training, and data management.
- IDSP shall ensure that all designated surveillance positions (SSO, DSO, epidemiologists, data managers) remain filled.
- Periodic refresher training for all surveillance staff (DSO, MOs ANMs ASHAs) shall be conducted, with training records maintained.
- As NCDC regional centres and state branches are commissioned, these are expected to play a critical role in sustaining and monitoring activities.

**DWR form attached in Annexure IV*

10. Acute Flaccid Paralysis Case: Surveillance, Sample Collection & Transport

After India was declared polio-free in 2014 by the WHO South-East Asia Region (SEARO), the country did not stop polio surveillance. In fact, surveillance has been maintained and even intensified in some respects to prevent re-emergence, especially due to the risks of:

- Importation of poliovirus from endemic countries
- Circulation of vaccine-derived poliovirus (VDPVs) due to low routine immunization coverage
- Gaps in routine immunization in underserved or mobile populations.

AFP Processes *(Figure 1)*

1. **Target Population** - All children <15 years with sudden onset of weakness or paralysis.
2. **Reporting Time** - Within 48 hours of AFP detection.
3. **Time of Collection of Stool Specimens from an AFP Case** - The first specimen should be collected as early as possible after case is notified. Stool samples can be collected within 60 days of onset of paralysis; however, an adequate sample is defined as one collected within 14 days of onset. The second sample is collected at least 24 hours apart after the first specimen in view of intermittent shedding of the poliovirus.
4. **Procedure for Collection of Stool Specimens** -
    a. Use a clean plastic screw-cap container to collect fresh stool from the child's diapers or get the child to defecate onto a clean paper.
    b. A label with name, EPID number, specimen number and date of sample collection should be pasted on the side of the container *(Table 5)*.
    c. The EPID Number is in the format - Country-State-District Code-Year of paralysis onset- Case No. (Example: IND-UP-LNO-25-002).
    d. The stool collection kit and stool shipment carrier with frozen ice packs should be provided to the family so that they can collect samples from the child in case the child is at home or to be given to hospital staff if case is in a hospital.
    e. Collect a volume of stool about the size of one adult thumb size (8 grams). Use the spoon attached to the cap of the container to place the specimen from the diaper/ paper in the sample container, avoiding soiling the brim of the container *(Table 5)*.
    f. After collection, immediately place the container in a zip-lock bag, seal the bag and place the zip-lock bag in stool shipment carrier (triple layer packaging) with frozen ice packs *(Table 5)*.
    g. Data entry should be done in VSIMS/ IHIP portal ensuring that the data entered in the CIF, LRF and the specimen container match.

Table 5: *Essential Parameters for Stool Collection*

S. No.	Component	Description
1.	**Specimen**	8 grams of stool (approximately one adult 'thumb-size' amount for each specimen)
2.	**Number**	Two specimens, taken at least 24 hours apart
3.	**Timeline**	Within 14 days of onset of paralysis, and not later than 60 days following paralysis onset
4.	**Label**	Case Identification (EPID) Number, Date of Specimen Collection, Child's Name and Sample Number (1 or 2)
5.	**Transportation**	2-8°C (Cold chain)

h. Complete the laboratory request form (LRF) for each case clearly recording the EPID number of the case mentioned on the label of the specimen collection container. LRF can be directly generated through the VSIMS portal.

i. When shipping the sample to the lab, LRF should be enclosed in a separate plastic zipper bag/envelope.

5. **Transportation of Specimens** -

a. As soon as both specimens are collected, they should be transported to the designated laboratory in 'cold chain' (2-8°C). If there is delay in collection of 2nd stool specimen, the 1st specimen can be transported to laboratory avoiding stool holding.

b. If there is likely to be a delay in shipment, the specimens must be placed immediately in a deep freezer.

c. The time interval between shipment of second sample and receipt at the designated Laboratory should not exceed 72 hours. If this is not possible, the specimens must be frozen (-20°C) and then shipped frozen, with ice packs that have also been frozen at -20°C.

d. Do not mix stool shipment carriers with vaccine carriers which are used for vaccines or other medicines. If contamination is suspected, refrigerators, cold boxes, vaccine carriers and ice packs can be disinfected with a solution of 1-part bleaching powder to 10 parts water or freshly prepared 1% sodium hypochlorite solution for a contact period of at least half an hour.

Responsibility should be duly assigned for sample collection, storage (till sample is transported to designated laboratory), transportation to designated laboratory, and, and provision of specimen containers and shipment carriers.

6. **Laboratory Results** - Laboratory results will be received at CSU/SSU/DSU. The possible laboratory results are listed in *Table 6*

Table 6: *Laboratory Results for Polio Virus Strains*

Lab Results	Type of virus	Reported as
OPV-like or Sabin-like (SL), or nOPV2-like	Vaccine strain poliovirus type 1, 2 or 3	SL1, SL2, SL3, nOPV2-like
Wild poliovirus	Wild poliovirus type 1, 2 or 3	WPV1, WPV2, and WPV3
Vaccine-derived poliovirus	Vaccine-derived poliovirus type 1, 2 or 3	VDPV1, VDPV2, VDPV3
Non-polio Enteroviruses	Non-polio Enteroviruses	NPEV
No virus isolated	No virus isolated	Negative

7. **Sixty-day follow-up examination** - The following categories should undergo 60-day follow-up
    a. AFP cases with inadequate stool specimen collection
    b. AFP cases with isolation of vaccine virus
    c. AFP cases with isolation of wild poliovirus / VDPVs

Sixty-day follow-up is primarily done to determine the presence/absence of residual paralysis. During the 60-day follow-up examination, the investigator must ensure correct documentation in the CIF, status of the paralysis and other clinical profiles. Following completion of 60 days follow-up, all the relevant documents should be sent to Expert Review Committee (ERC) for classification of case as Discard or Compatible.

8. **Active/ Passive Surveillance** - VPD surveillance is strengthened through active and passive surveillance as detailed in *Table 7*.
    a. Passive Surveillance: when data/reports are sent by designated health facilities or individuals on their own, periodically as a routine.
    b. Active Surveillance: when a designated official, usually external to the health facility visits periodically and seeks to collect data from individuals or registers, logbooks, medical records at a facility to ensure that no reports/data are incomplete or missing.

Table 7: *Active/Passive Surveillance*

Activities	
Health Facility Visits	Surveillance Officers at districts to regularly visit government health facilities, private hospitals, clinics, physiotherapy centers, traditional healers to ensure effective surveillance
Zero Reporting	Even if no cases are found, facilities (Reporting Units) must submit Zero reports weekly to confirm passive surveillance
Line Listing	Health facilities must maintain updated line list of all AFP cases identified and reported
Community Surveillance	Collection of data from individuals and households at the village/ locality level other than institutions or facilities In high-risk areas (e.g. urban slums, nomadic populations, conflict zones), community informants (such as ASHAs, Anganwadi workers, teachers, traditional healers) to be trained in AFP case identification and notification

Based on the prioritization, selected reporting units and informers are visited regularly on a planned basis for the specific purpose of searching for AFP cases and to sensitize the Reporting Site staff basis following schedule -

Sensitization of reporting units according to the priority

- 100% of VHPs to be visited at least twice a month.
- 100% of HPs to be visited at least once a month.
- 100% of LPs to be visited at least once a year.
- 100% of LPs to be telephonically contacted at least once in four months.

Minimum Surveillance Quality Indicators and Timelines

To ensure the effectiveness of VPD surveillance, a set of minimum surveillance quality indicators and timelines have been established at national levels as detailed in *Table 8 and 9* respectively. These indicators such as Non-Polio AFP rate, stool adequacy rate, and timeliness of investigation, etc. serve as benchmarks to assess the sensitivity and completeness of the surveillance system. Adherence to prescribed timelines for case detection, reporting, investigation, and sample shipment is critical to ensuring that surveillance data remains actionable and meets the standards required for maintaining India's polio-free status.

Table 8: *Surveillance Indicator*

Indicator	Standard
Non-polio AFP rate	≥2/100,000 children <15 years of age
% Stool adequacy	≥80% of AFP cases with 2 samples collected within 14 days of paralysis onset
Timeliness of investigation	≥80% of AFP cases investigated within 48 hours
Lab confirmation	Stool samples tested in WHO-accredited polio labs

Table 9: *Timelines for Various Activities in AFP Surveillance**

S. No.	Activity	Timeline
1.	Notification of AFP case	Immediately
2.	Case Investigation	Within 48 hours of notification Any case that has onset within last 6 months from date of notification should be investigated
3.	Collection of stool samples	Within 14 days of onset of paralysis (preferably) But, not more than 60 days following paralysis onset
4.	Interval between two stool samples	At least 24 hours
5.	Interval between collection of 2nd stool sample and receipt at designated laboratory	72 hours
6.	Primary Isolation Report from Laboratory	Within 14 days of sample receipt in lab
7.	Laboratory Report in case Polio virus is isolated	Within 21 days of sample receipt in lab
8.	Final Classification of an AFP case (confirmed polio, VDPVs, discarded or compatible with poliomyelitis) by Expert Review Committee	Within 90 days
9.	Expected Reporting Rate	≥2 AFP cases per 100,000 children under 15 (non-polio AFP rate)

Epidemiological Investigation of WPV/VDPV/SL2

Following laboratory confirmation of WPV or VDPV from an AFP case, an immediate epidemiological investigation** is launched in parallel with IHR notification to WHO.

A rapid response team is to be deployed to the affected area to conduct detailed case investigation capturing vaccination history, onset date, travel history, and exposure mapping, alongside active case search in the surrounding population and contact tracing within the household and community.

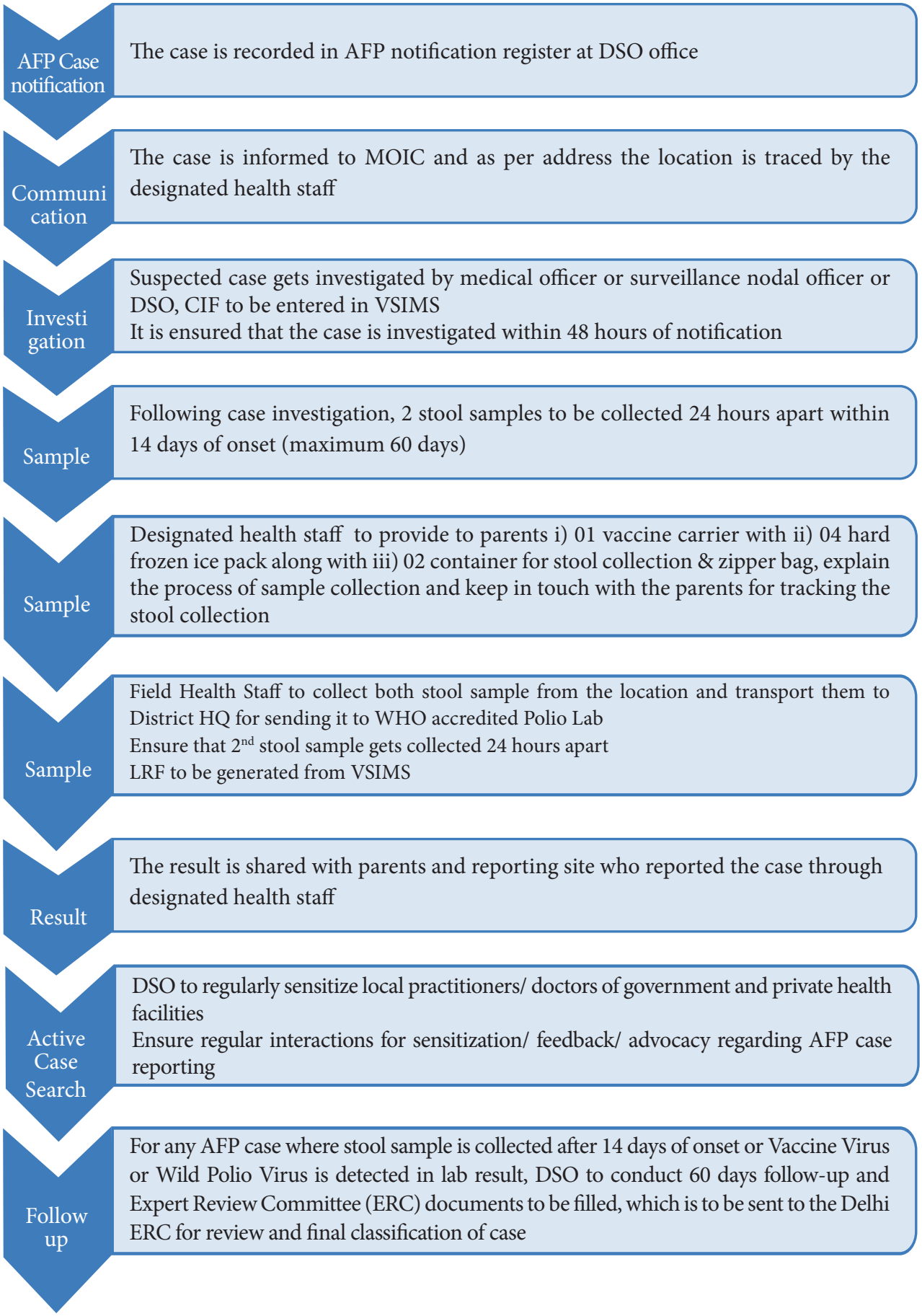
Environmental surveillance through sewage sampling to be intensified to detect silent transmission beyond the index case. Concurrently, a population immunity gap assessment is undertaken using routine immunization coverage data and rapid field surveys.

Based on the geographic extent of transmission risk and the immunity landscape, the response is calibrated ranging from targeted mop-up supplementary immunization activities for an isolated detection to large-scale multi-round SIAs for a confirmed outbreak. Throughout, AFP surveillance indicators are closely monitored to ensure no linked cases are missed, and findings are consolidated into follow-up review to strengthen preparedness for future events.

**For further details, refer to Guidelines for Poliomyelitis Surveillance – 2024. https://www.mohfw-dohfw.gov.in/static/uploads/2025/12/74df2fa471c759fa4f054a32f4d56e5d.pdf*

***Epidemiological Investigation Checklist WPV/VDPV/SL2 attached as Annexure V*

Figure 1: *Workflow of AFP Case Investigation*



11. Vaccine-Derived Poliovirus (VDPV)

Vaccine derived poliovirus (VDPVs) are strains of poliovirus that have genetically mutated from the strain contained in the oral polio vaccine. VDPVs have been classified as:

1. Circulating Vaccine Derived Poliovirus (cVDPV) - is a VDPV demonstrating person-to-person transmission in the community based on evidence from human and/or environmental detections of genetically linked VDPVs
    a. From at least two individuals (not necessarily AFP cases), who are not direct (i.e. household) contacts;
    b. from one individual and one or more environmental surveillance (ES) samples;
    c. from two or more ES samples if they were collected at more than one distinct ES collection site (no overlapping of catchment areas), or from one site if collection was more than two months apart.
2. Immunodeficiency associated VDPV (iVDPV) - is a VDPV isolated from individuals that have evidence of primary immunodeficiency (PID). Unlike immunocompetent persons, who excrete the vaccine virus for a limited period, in rare cases individuals with primary immunodeficiency may excrete a genetically diverged vaccine virus for an extended period after receiving OPV.
3. Ambiguous VDPV (aVDPV) - is a VDPV for which the VP1 sequence is not genetically linked to other previously identified VDPV sequences and there is no evidence of primary immunodeficiency (PID) if the virus has been isolated from an individual. A VDPV sequence will be classified as ambiguous based on laboratory results and epidemiological investigation and in communication with field teams, technical experts and laboratory staff at WHO HQ and the WHO Regional Office. Isolates may be from persons with no known immunodeficiency or from an environmental sample, without evidence of circulation.

Detection of VDPVs from any source should be properly investigated and responded through a standard protocol. A proper investigation will not only help the program to correctly classify the VDPVs in one of its three types, but will also bring the insight for building an appropriate response.

Very rarely, VDPVs are found to be able to regain the ability to circulate and paralyze, causing polio outbreaks (cVDPVs) in areas with immunity gaps. Even more rarely, VDPVs were shown to persist for years in some individuals with primary immunodeficiency syndromes (iVDPVs). Once wild poliovirus transmission has been stopped globally, the vaccine viruses will be the only source of polioviruses in the community that could potentially lead to the re-emergence of polio.

VDPVs detection -VDPVs are normally detected from stool samples of an AFP case or from sewage samples, through the AFP and environmental surveillance for poliovirus. However, rarely it can be isolated in research projects that are directed towards identification of polioviruses in immunocompromised patients or through iVDPVs surveillance. Though the long term carrier stage is very rare in poliomyelitis cases but some long time excretors of poliovirus are known to exist. Such

excretors are normally B cell immunocompromised patients that have been given OPV or are exposed to vaccine poliovirus strain as secondary contacts. These patients may or may not develop signs and symptoms of acute flaccid paralysis. The vaccine poliovirus thus identified from immunodeficient patients, most of the time, has diverged by many nucleotide changes from its parent vaccine strain and they are classified as iVDPVs.

VDPVs can be identified in the stool samples of a person as -

- AFP case
- Non-AFP case as healthy contacts or iVDPV surveillance

In both the scenarios, the shedder of VDPVs is known and specific response can be built accordingly. Below are the response actions that should be executed systematically: *(Figure 2)*

1. **Investigation of the case and contact** - Conduct a detailed clinical, epidemiological and social investigation of the case and contacts urgently.

    a. **Clinical history** - Elicit a detailed clinical history since birth. History of any underlying chronic illness, delayed milestones, repeated infections or hospitalization can provide a clue about the immune status of a child. Often, such cases initially diagnosed as GBS are given intravenous immunoglobulins (IVIG). Parenteral administration of immunoglobulins will raise the antibody titres in blood of the subject temporarily for about a month as half-life of such products is around 28 days. This passively acquired immunoglobulins will mask the true immune status of the case when serum will be tested for antibody titres. Therefore, it is extremely important to take a detailed treatment history especially for IVIG therapy. If the case is not hospitalized then IVIG therapy is usually given in day care and it takes 4-6 hours for the infusions.

    b. **Clinical examination** - Besides conducting a detailed neurological examination, look for normal functioning of other systems. For example, look for the signs of malnutrition or disease of other systemic functions. If need be, opinion of a specialist (pediatrician, neurologist or as appropriate) can be sought. If child is already under some medical care, try to get the copy of medical records.

    c. **Laboratory investigation** - Certain blood investigation should be conducted to assess the blood counts and antibody titers against poliovirus.

        - **2 ml in EDTA vial –** for complete haemogram from any quality Government / private pathology laboratory

        - **3 ml in plain vial for serum specimen** - after serum separation, the sample need to be shipped to NIV Mumbai under cold chain. Use of vacutainer tubes for taking serum sample should be explored but not mandatory.

    d. **Stool specimen collection** - After identification of a VDPVs case, initially two stool specimens should be collected with an interval of 24 hours just like in any AFP case to evaluate if the child is still excreting virus or not. If yes, then collect one stool specimen on monthly basis until the result of two consecutive stool specimens becomes negative.

2. **Family history** - Detailed medical history of the family members especially of the siblings is equally important. Certain immunodeficiencies can run as genetic disorder or are the result of consanguineous marriages. So it's important to elicit family history on still births, early child deaths, long term illness or repeated hospitalization of other family members and close relatives.

3. **Contact sampling** - To assess the spread or circulation of VDPVs among the family members or in the community, contact sampling should be done for each VDPVs case irrespective of its type and category.

   a. **Family contact sampling** - Collect one stool sample from all household members irrespective of age group. A linelist to be generated with basic identification details along with their OPV immunization history.

      To maintain uniformity and to facilitate analysis of data, the household contact specimens should be labeled as EPID No – H01 (H02, H03…). For example, if the case have 7 household members, the EPID No of 5th member will be KA-BDR-10-50-H05

   b. **Neighbour/community sampling** - Collect 32 samples from the neighbour/ community in 4 different age groups. The maximum permissible samples from a single household – four.

      i. 0 – <2 yrs = 8 samples

      ii. 2 – <5 yrs = 8 samples

      iii. 5 - 10 yrs = 8 samples

      iv. > 10 yrs = 8 samples

      The neighbourhood/community contacts should be labelled as – EPID No-N0101 (the first 2 digits after N stands for the neighbourhood house number and the next 2 digits are for the number of contact) for example –

      i. **Second contact in first neighbourhood house** - KA-BDR-10-50-N0102

      ii. **Fourth contact in the second neighbourhood house** - KA-BDR-10-50-N0204

   c. **Health facility contact sampling** - Collect contact sample from the health facility/ facilities where the patient has received treatment for PID in last one month. The contact specimen should be labelled as EPID No – F01 01 (F01 02, F02 01….); F01 for first facility, F02 for second facility and so on.

4. **Vaccination** -

   Vaccination of all household and health facility contacts of the case with fractional Inactivated Polio Vaccine (fIPV – 0.5 ml, intramuscular) is recommended during a VDPVs detection. This provides direct protection to individuals at highest risk of exposure, enhances population immunity in the immediate contact setting, and helps interrupt further transmission.

5. **Assessment of population immunity -**

    a. **Rapid RI assessment survey of the area -** Minimum of 250 households in the area should be sampled especially for DPT3/OPV3 and IPV1/IPV2/IPV3 coverage. The RI coverage should be assessed in children <5 years. In every household, the youngest <5 year old child should be taken for assessment of RI coverage.

    b. **Assessment of coverage of OPV during last 3 SIA -** Along with RI assessment assess the coverage of OPV vaccination done through last 3 SIA.

    c. **Assess the immunization** - Assess the coverage of all the vaccines with a focus to OPV and fIPV for last 3 years.

6. **Increase sensitivity of AFP surveillance and active case search in the community** - The surveillance system is put on high alert to detect any signs of poliovirus transmission in the affected area. Visit all the health care providers in the area, including traditional healers and private practitioners as part of active case search. Active case search in the community should be done during the process of assessment of population immunity.

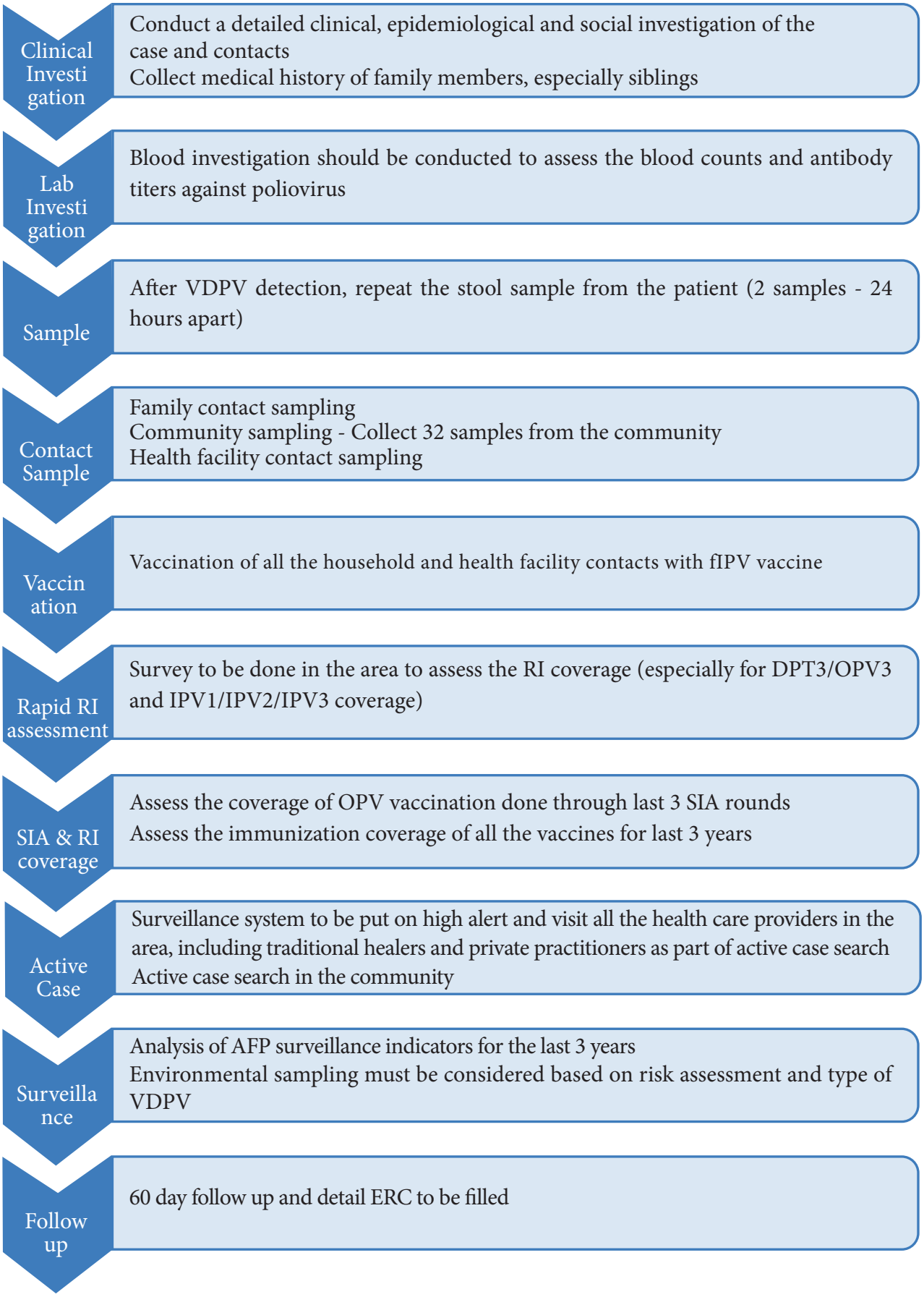
7. **Analysis of surveillance system** - Detailed analysis of Acute Flaccid Paralysis (AFP) surveillance indicators for the preceding three years should be conducted. This analysis should include number of AFP cases, AFP rate, and non-polio AFP rate, percentage of cases with adequate stool specimens collected within 14 days of onset, percentage of cases notified within 10 days of onset, and percentage of cases investigated within 48 hours of notification. Assessment of these indicators is essential to evaluate the sensitivity, timeliness, and overall quality of VPD Surveillance.

8. **Environmental sampling** - Should be considered based on risk assessment and type of VDPVs. It is mandatory for the VDPVs case events.

9. **60 day follow up** - DSO has to investigate the case and detailed ERC to be filled which is to be sent to Delhi ERC for review.

Oral polio vaccine is contraindicated in immunocompromised children due to the risk of prolonged virus excretion and development of immunodeficiency-related VDPVs; IPV should be used instead.

Figure 2: *Workflow of VDPV Case Investigation*



12. Suspected Measles & Rubella Cases: Surveillance, Sample Collection & Transport

India is committed to the elimination goal of measles and rubella (MR) in line with the WHO South-East Asia Regional Office (SEARO) goal of eliminating both diseases where Elimination means:

- Zero endemic measles and rubella transmission for ≥12 months
- With high-quality surveillance to confirm absence of transmission

To achieve this, India must conduct *highly sensitive* case-based fever-rash surveillance including active search for cases that meet specific WHO standards.

Suspected MR (Fever Rash) Surveillance - Any person with acute fever and maulopapular (Non - Vesicular) rash OR any person in whom a clinician or health worker suspects measles or rubella infection.

1. **Target Population** - All age groups for both measles and rubella
2. **Surveillance type** - Case-based surveillance with lab confirmation
3. **Reportable conditions** - Any suspected measles/rubella case based on the case definition
4. **Active Case Search Requirement** - India's ability to achieve and sustain MR elimination depends on maintaining intense, high-quality active case search and ensuring every single suspected case is timely reported, investigated and sample tested in WHO accredited laboratory

   a. Health facility Search

      i. Monthly visits by surveillance teams (e.g., State /UT and district health staff) to the :

      - Government hospitals - Medical College, DH, SDH, CHCs, PHCs, / UPHCs
      - Private hospitals/clinics
      - Paediatric/neonatal wards
      - Dermatology, ophthalmology, and general OPDs
      - Traditional healers /unregistered healthcare providers

      ii Line listing of all fever rash cases seen in the previous 30 days

      iii Verification of zero reporting if no cases found (at Reporting Units)

   b. Community Surveillance

      i Engagement of frontline health workers (ASHAs, AWWs, ANMs) to report fever rash illness from the community

      ii Weekly interaction with school teachers, community leaders, informal healthcare providers

      iii Focus on -

- High-risk populations - urban slums, nomads, migrants, border areas
- Women of reproductive age (for rubella/Congenital Rubella Syndrome surveillance)

5. **Outbreak detection and Notification** -

   a. Outbreak is to be flagged if any of the below mentioned criteria is met -

      i ≥5 suspected cases of measles/rubella reported in a block/urban ward/planning unit in the past four conseqective weeks; or

      ii ≥5 suspected cases of measles/rubella in and area bordering multiple contiguous blocks/ urban ward/ planning unit in the past four conseqective weeks; or

      iii ≥1 suspected cases of measles/rubella death in a block/ urban ward/ planning unit.

   b. Preliminary search must be initiated withn 72 hours of outbreak flagged.

6. **Assigning a unique EPID Number** - An EPID number is assigned for an investigated case, or a flagged outbreak or additional cases found on detailed investigation of an outbreak. The examples of a unique case identification number (EPID number) allotted to suspected cases or outbreak is shown in *Table 10*

7. **Specimen types recommended for Measles & Rubella** - Diagnosis of Measles and Rubella is done by detection of specific IgM antibodies in the serum. For genotypic characterization of Measles and Rubella viruses, collection of throat swab or urine or nasopharyngeal swabs are recommended (*Table 11).*

Table 10: *Assigning EPID Number*

For MR suspected cases	For MR flagged outbreak
MR-IND-UP-MRD-25-001	MOB-IND-MH-RTG-25-001-001
MR- indicates disease measles rubella	MOB indicates measles rubella outbreak
IND- Country code	IND- Country code
UP- State code/Province code	MH- State code/Province code
MRD- District code	RTG - District code
25- year of rash onset	25- year of outbreak reporting
001- Serial no of cases in that year in the same district	001- Serial number of outbreaks in that year in the same district
	001 serial number allotted to each case identified during the detailed investigation of an outbreak

8. Procedure for Collection of Specimens -

A. Blood specimen for Serology

i A single serum sample should be obtained from each Measles/Rubella suspected case at the time of first contact (during case investigation).

ii A blood specimen can be collected within 28 days of rash onset, from any age group with no history of Measles/Rubella Vaccination in last 1 month.

iii Explain to the subject/parents about blood collection.

iv Label a plain blood collection tube or a vacuum-based tube (red/yellow capped) with EPID number, patient's name, type of sample (serum), and date of collection.

v Clean hands with an alcohol-based disinfectant and put on a new pair of disposable gloves. Tie a tourniquet proximal to the site of puncture. Clean the venipuncture site by wiping with an alcohol swab using a circular motion from the center to the periphery; and allow the area to dry for at least 30 seconds.

vi Collect 2-3 ml blood by venipuncture using the vacuum-based tube assembly or by syringe and needle system.

vii Soon after collection, release the tourniquet.

viii The tube containing blood samples should be kept undisturbed at room temperature for at least 30 minutes to enable clotting of blood and to prevent hemolysis caused by shaking of the tube during transportation.

ix After the clot formation, keep the tubes in sample shipment carrier with conditioned ice packs for transportation to local center having centrifuge for serum separation.

x To prevent excessive shaking of sample or freezing of sample by direct contact with ice packs during transportation, proper packing of sample should be done in the vaccine carrier using rack to keep the tubes in upright position.

xi If clot does not happen even after keeping 30 minutes at room temperature, then usually clot retraction will happen in 2 to 8 hours at 4-to-8-degree temperature.

xii After clot retraction, the whole blood should be centrifuged at 1000-1500g (3000 rpm) for 10 minutes to separate the serum.

xiii Label a vial with EPID number, patient's name, type of sample (serum), and date of collection.

xiv The serum should be carefully transferred aseptically with a pipette to the labelled vial avoiding extracting red cells.

xv Keep the vial containing serum in a zip lock bag, seal the zip lock bag and put it in a shipment carrier box (triple packaging) with conditioned ice packs for transportation to designated MR laboratory.

xvi Specimens should be shipped to the designated laboratory as soon as possible and maximum within 5 days in cold chain. Do not wait to collect additional specimens before shipping.

xvii In a rare scenario, the sterile serum can be stored at 4–8-degree temperature for a maximum period of 7 days. In case of delay of more than 7 days is anticipated, sera should be frozen at -20°C and shipped to designated laboratory with frozen ice packs as soon as possible.

xviii Repeated freezing and thawing can have detrimental effects on the stability of IgM antibodies.

xix Data entry should be done in VSIMS/ IHIP portal ensuring that the data entered in the CIF, LRF and the specimen container match

B. Collection of Throat swab/nasopharyngeal swab/urine samples for virology

i The molecular detection or isolation of Measles or Rubella virus in clinical specimens is done mainly for genotypic characterization of the viruses to identify the transmission chains. This provides very important information regarding the likely origin of measles or rubella virus.

ii Throat swab, urine or nasopharyngeal samples are the preferred samples for viral isolation/ molecular detection for both Measles and Rubella viruses.

iii Preference should be given to collecting throat swabs over nasopharyngeal swab or urine.

iv Any one sample, either throat swab or nasopharyngeal swab or urine, should be collected from each suspected case within 7 days of onset of rash.

v Blood sample and throat swab may be collected from the same case or for all sporadic cases if the size of the outbreak is small.

vi However, in case of outbreaks, serology samples to be collected from at least 5 cases and virology samples from two cases.

vii The throat swab or nasopharyngeal swab should be transported in viral transport media (VTM) tubes in the cold chain

a. Throat-swab

i Wear mask and gloves.

ii Label the Viral Transport Medium (VTM) tube with EPID ID, patient's name, type of sample, and date of collection

iii Explain the procedure to the parents or patient (in case of an adult).

iv Ask patient to open mouth, with a tongue depressor hold tongue away.

v Locate areas of inflammation and exudate in posterior pharynx and tonsillar region

vi Rub the swab (cotton or dacron) back and forth in the inflamed area avoiding soft palate and tongue

vii Immediately place the swab inside the VTM tube.

viii Break the remaining portion of the stick that extends outside the tube and cap the vial securely (it is best to wrap the tape around the cap to prevent any leakage).

ix Ship at 4-to-8-degree temperature.

b. Nasopharyngeal swab

i Wear mask and gloves

ii Label the VTM tube with EPID ID, patient's name, type of sample, and date of collection

iii Explain the procedure to the parents or patient (in case of an adult).

iv Have the patient sit with his/her head against a wall or support (patients have a tendency to pull away during this procedure).

v Measure the distance between anterior nares to the lower lobe of the ear of one side.

vi Mark the swab with half of the above measured distance.

vii Ask the patient to blow the nose forcefully to remove any mucous plug.

viii Position the head slightly upwards and insert the swab along the floor of the nose up to the distance marked.

ix Do not force swab if obstruction is encountered before reaching the nasopharynx. One may remove the swab and try the other side.

x Try to leave the swab in place for 5–10 seconds to increase sensitivity.

xi Immediately place the swab in VTM vial and tighten the cap (it is best to wrap the tape around the cap to prevent any leakage).

xii Ship at 4-to-8-degree temperature

c. Urine

i Label the container for urine with EPID ID, patient's name, type of sample, and date of collection

ii Urine samples should be collected in the sterile container which should have a screw cap that can be tightened properly.

iii Give the labelled container to the patient/ parent for collection of urine

iv After collection the cap should be tightly closed

vi The container should be packed in the zip lock bag to avoid contamination of sample shipment carrier from any spillage.

Keep the tube/vial containing the throat swab/nasopharyngeal swab/urine in a zip lock bag, seal the zip lock bag and put it in a shipment carrier box (triple packaging) with conditioned ice packs for transportation to designated MR laboratory.

Specimens should be shipped to the designated laboratory as soon as possible (24 to 72 hours of collection). Both samples are rich culture media for bacterial growth and any delay in transportation will reduce chances of virus isolation.

Data entry should be done in VSIMS/ IHIP portal ensuring that the data entered in the CIF, LRF and the specimen container match.

Table 11: *Types of Samples to be Collected for Laboratory Diagnosis of Measles and Rubella*

Type of specimen	Test type	Volume to collect	Timing for specimen collection	Storage & transport conditions
Serum (venipuncture)	IgM antibody detection	2 ml of blood in an older age group; 1 ml for infants and younger children; 0.5 ml from small infants	Within 28 days after rash onset	4–8 °C
Throat, or nasopharyngeal (NP) swabs	Detection of viral RNA by PCR and viral isolation	Swab	Within 7 days after rash onset	4–8 °C
Urine	Detection of viral RNA by PCR and viral isolation	Minimum 50 ml (Preference first morning void).	Within 7 days after rash onset	4–8 °C

9. Case and outbreak classification

Case classification of each suspected case is based on clinical presentation, laboratory results and the epidemiological information elicited during case investigation and collected from the MR-CIF *(Figure 3 and 4)*.

Definitions

a. Adequate samples

- **Adequate serological sample** - A blood sample collected within 28 days of rash onset by venipuncture, with minimum quantity of 2 ml whole blood drawn to obtain at least 0.5 ml of serum after separation, with no signs of hemolysis in serum sample and received in the laboratory under proper cold chain conditions with appropriate documentation.
- **Adequate urine sample** - An adequate specimen for virology is a urine sample collected within 7 days of rash onset with 50 mL of urine collected in a sterile, leak proof container and received under proper cold chain conditions in the laboratory with appropriate documentation.
- **Adequate throat/nasopharyngeal sample** - An adequate specimen for virology is a throat/nasopharyngeal sample collected within 7 days of rash onset in viral transport media and received under proper cold chain conditions in the laboratory with adequate documentation.

b. Discarded Non-Measles Non-Rubella (NMNR) case - A suspected case that has been investigated and discarded as non-measles and non-rubella by:

- Laboratory result negative for measles and rubella, through serum sample testing in a proficient laboratory; and
- No epidemiological linkage to another confirmed measles or rubella case.

c. Laboratory-confirmed measles

- A case that meets the suspected measles case definition and is laboratory (serologically or virologically) confirmed as measles.

d. Laboratory-confirmed rubella

- A case that meets the suspected measles case definition and is laboratory (serologically or virologically) confirmed as rubella.

e. Epidemiologically-linked cases

- As a part of an outbreak investigation, additional suspected cases captured on line listing forms but without specimens collected are epi linked if they are part of a lab-confirmed outbreak

f. Clinically compatible measles case - A suspect case with fever and maculopapular (non-vesicular) rash for which no adequate laboratory specimen could be collected and is:

- Not epidemiologically linked to a laboratory-confirmed case of measles or rubella; and
- Not epidemiologically linked to another laboratory-confirmed communicable disease.

g. Clinically compatible rubella case - A suspect case with fever and maculopapular (non-vesicular) rash and one of arthritis/arthralgia or lymphadenopathy, for which no adequate laboratory specimen could be collected and is:

- Not epidemiologically linked to a laboratory-confirmed case of measles or rubella; and
- Not epidemiologically linked to another laboratory-confirmed communicable disease.

Figure 3: *MR Sporadic Case Classification*

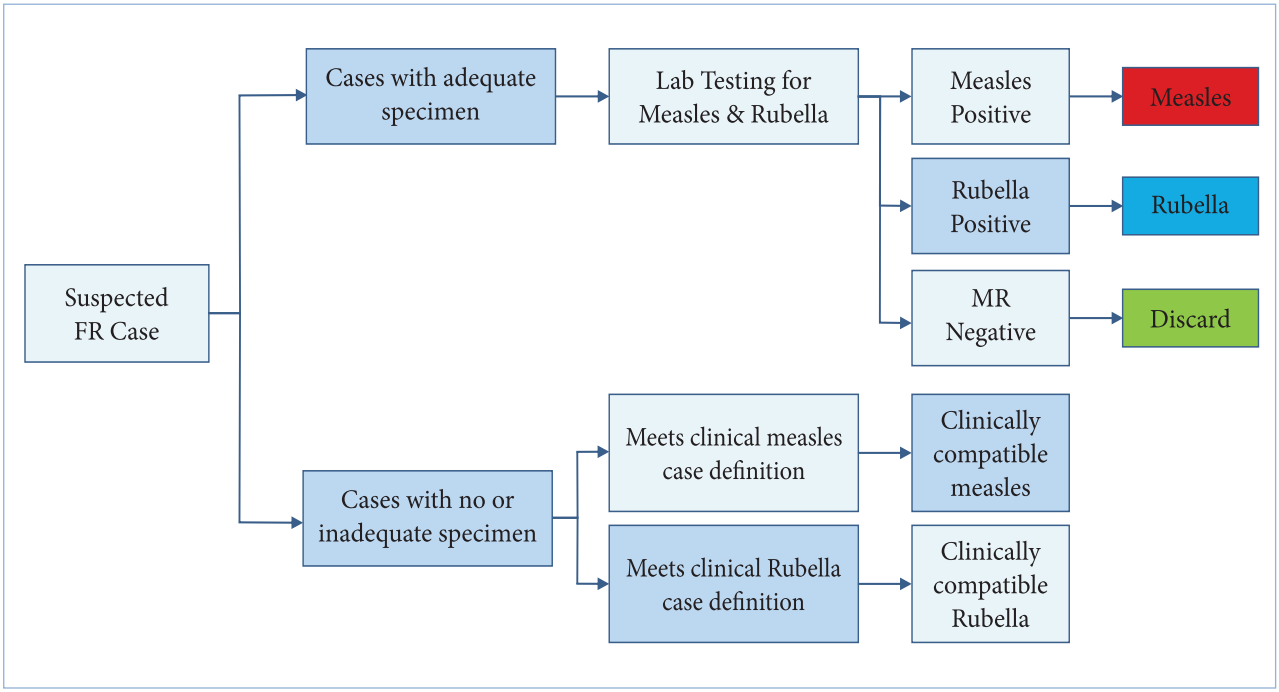
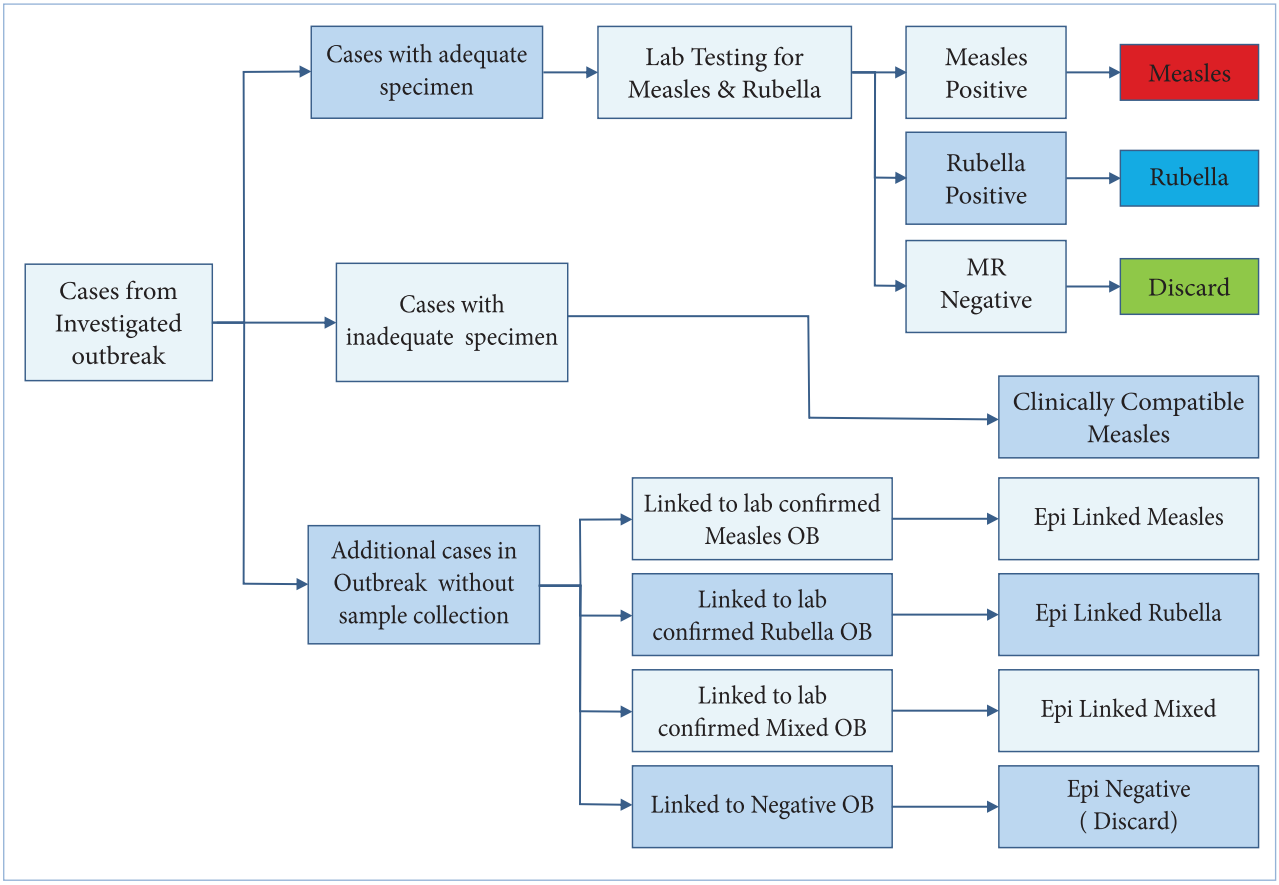
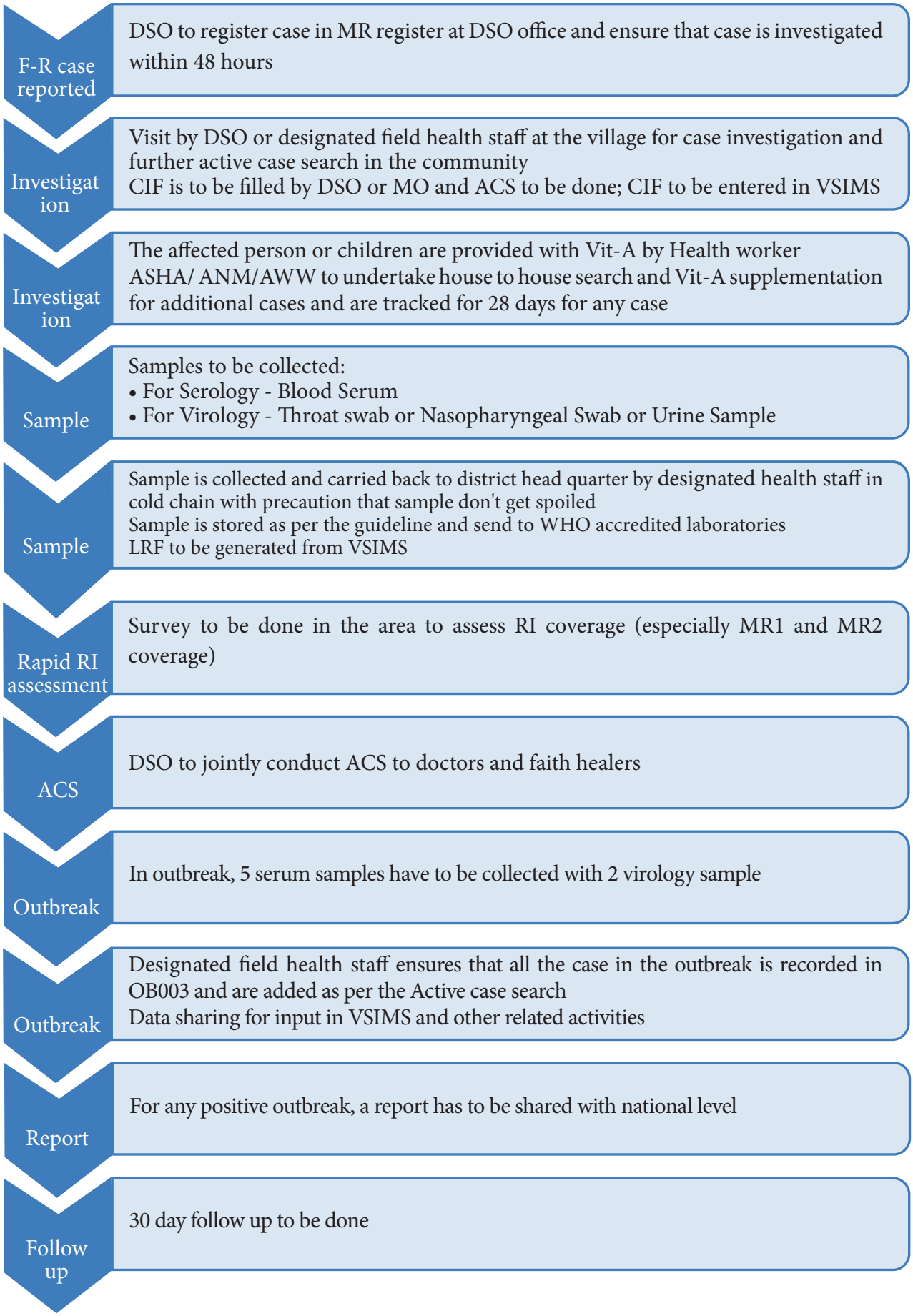


Figure 4: *MR Outbreak Classification*



5th meeting of MR IEAG, 2023 has recommended for shifting from sequential testing of measles and rubella to parallel testing to ensure no cases of rubella are missed

Figure 5: *Workflow of Fever-Rash (FR) Case Investigation*



13. Suspected Diphtheria, Pertussis & Neonatal Tetanus Cases: Surveillance, Sample Collection & Transport

Each reported case should be investigated using the designated CIF for DPT cases *(Figure 6)*. Each case shall be assigned a unique case identification code/EPID number (16-character alphanumeric code) -

- The first three characters are related to the suspected disease of the case; these are – DTH for diphtheria, PTS for pertussis and NNT for Neonatal Tetanus.
- The remaining 13 characters determine time, place and person identification.

For example, if Bulandshahr district of Uttar Pradesh is reporting the first diphtheria case of 2025, then identification code allotted will be DTH-IND-UP-BLS-25-001, where DTH- Diphtheria, IND- Country Code, UP- State Code, BLS-District Code, 25- Year of Onset, 001- Serial number of diphtheria case of the district in that year

Laboratory confirmation of Diphtheria and Pertussis is required for case classification of clinically suspected cases. Confirmation of suspected cases of neonatal tetanus will be done only on a clinical basis and does not require any laboratory diagnostic test.

Specimen types recommended for Diphtheria and Pertussis - The Causative agents for Diphtheria (Corynebacterium diphtheriae) and Pertussis (Bordetella pertussis) have fastidious growth requirements and are susceptible to drying; therefore, the use of transport media is recommended to enhance detection.

- Recommended sample for Diphtheria is Throat swab.
- Recommended samples for Pertussis are nasopharyngeal swab and serum.

Samples should be collected as early as possible during the course of symptoms/illness of the suspected cases *(Table 12)*.

1. **Diphtheria: Collection of throat swabs**

    a. A minimum of 2 samples to be collected at same time.
    b. Standard precautions should be observed when collecting any biological specimen.
    c. Explain the procedure to the parents or patient (in case of an adult).
    d. Depress the tongue with a tongue depressor.
    e. Use sterile throat swab made of cotton or polyester or Dacron.
    f. Rub the swab with a slight pressure over visible white spots or inflamed area of tonsils and posterior pharynx without touching the tongue, uvula or inside of the cheeks.
    g. If membrane is visible, avoid rubbing the membrane due to risk of bleeding.
    h. Immediately place the throat swab sample in a labelled (Epid number, name, sample type- throat swab) Amies transport medium.
    i. Cut the shaft of the swab to fit into the tube and cap it securely.
    j. Data entry should be done in VSIMS/ IHIP portal ensuring that the data entered in the CIF, LRF and the specimen container match before sending the sample to designated laboratory.

k. Ship the specimen at 2-8°C to the designated laboratory.

2. **Pertussis: Collection of nasopharyngeal swabs** - For laboratory diagnosis of Pertussis, it is mandatory to collect nasopharyngeal swab or aspirate. Throat swab is not recommended for laboratory confirmation of Pertussis.

   a. A minimum of 2 samples are recommended.
   b. Standard precautions should be observed when collecting any biological specimen.
   c. Explain the procedure to the parents or patient (in case of an adult).
   d. Obtain a sterile thin flexible nasopharyngeal swab made up of dacron or nylon. Cotton and calcium alginate swabs are not to be used
   e. Have the patient sit in the mother's lap or with head against a wall or a support as patients have a tendency to pull away during this procedure
   f. Measure the distance between anterior nares to the lower lobe of the ear of one side
   g. Mark the swab with half of the above measured distance
   h. Position the head slightly upwards and insert the swab along the base of the nose up to the distance marked. Avoid insertion of swab in upward direction
   i. Do not force swab if obstruction is encountered before reaching the nasopharynx. Remove swab and try the other side
   j. Try to leave the swab in place for 5-10 seconds to increase sensitivity
   k. Immediately place the swab in labelled (Epid number, name, sample type- nasopharyngeal swab) Amies transport media with charcoal and tighten the cap of specimen collection container
   l. Data entry should be done in VSIMS/ IHIP portal ensuring that the data entered in the CIF, LRF and the specimen container match before sending the sample to designated laboratory.
   m. Ship the specimen at 2-8°C to the designated laboratory.

3. **Pertussis: Collection of serum sample** - It is recommended that one serum sample should be obtained from suspected Pertussis cases.

   a. Standard precautions are recommended when collecting blood specimen
   b. Explain to the patient/parents about blood collection.
   c. Label a plain blood collection tube or a vacuum based tube (red/yellow capped) with Epid number, name, sample type- serum.
   d. Clean hands with an alcohol-based disinfectant and put on a new pair of disposable gloves. Tie a tourniquet proximal to the site of puncture. Clean the venipuncture site by wiping with an alcohol swab using a circular motion from the center to the periphery; and allow the area to dry for at least 30 seconds.
   e. Collect 2-3 ml blood by venipuncture using the vacuum-based tube assembly or by syringe and needle system.

f. Soon after collection, release the tourniquet.

g. The tube containing blood samples should be kept undisturbed at room temperature for at least 30 minutes to enable clotting of blood and to prevent hemolysis caused by shaking of the tube during transportation.

h. After the clot formation, keep the tubes in vaccine carrier with conditioned ice packs for transportation to local center having centrifuge for serum separation.

i. To prevent excessive shaking of sample or freezing of sample by direct contact with ice packs during transportation, proper packing of sample should be done in the vaccine carrier using rack to keep the tubes in upright position.

j. If clot does not happen even after keeping 30 minutes at room temperature, then usually clot retraction will happen in 2 to 8 hours at 4-to-8-degree temperature.

k. After clot retraction, the whole blood should be centrifuged at 1000-1500g (3000 rpm) for 10 minutes to separate the serum.

l. Data entry should be done in VSIMS/ IHIP portal ensuring that the data entered in the CIF, LRF and the specimen container match before sending the sample to designated laboratory.

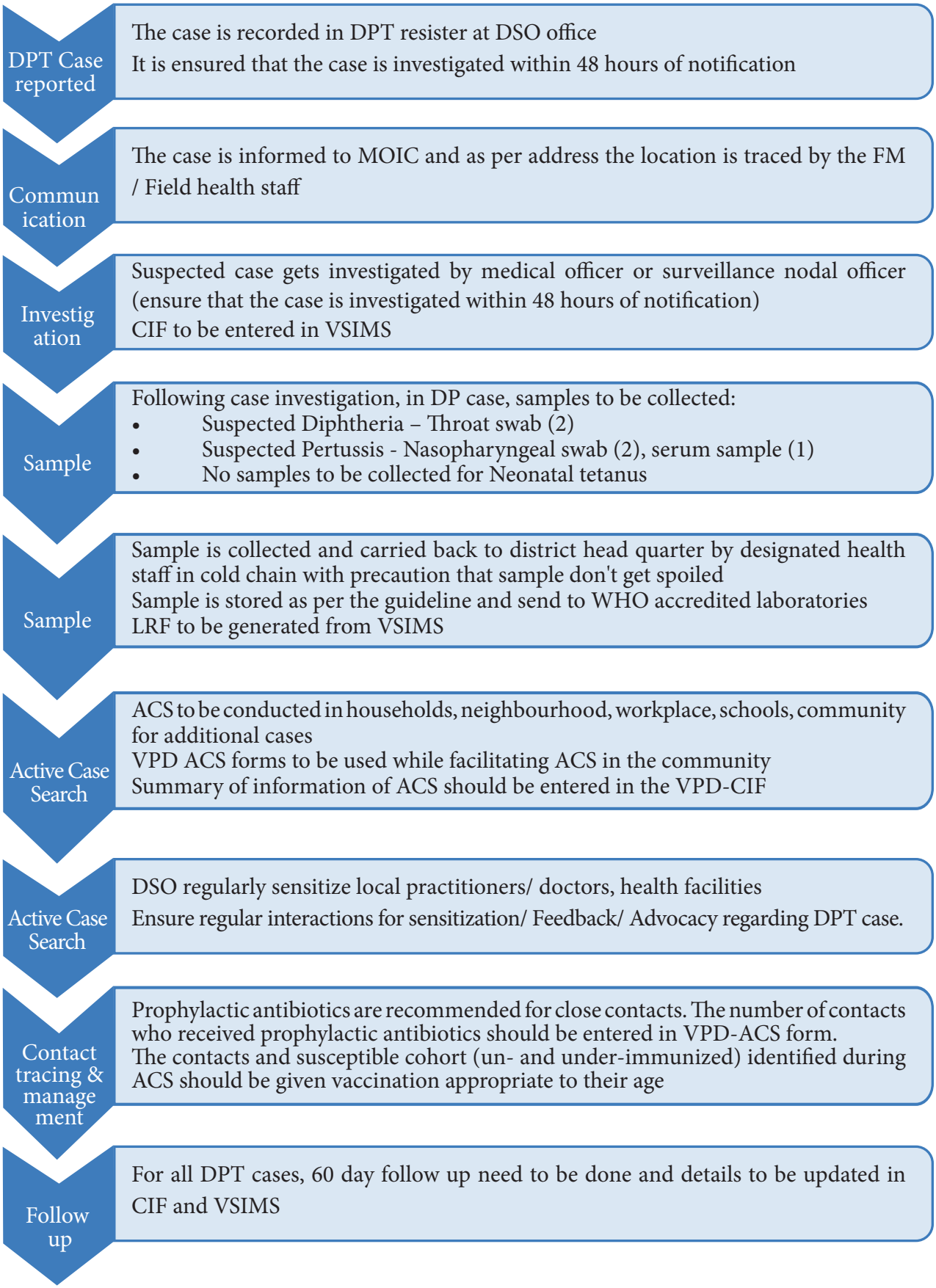
m. Ship the specimen at 2-8°C to designated laboratory.

Table 12: *Details of sample collection for laboratory diagnosis of Diphtheria and Pertussis*

Details	Diphtheria	Pertussis	
Time of collection of samples from onset of symptom	Within 4 weeks (of date of onset of sore throat)	Within 4 weeks (of date of onset of cough)	Within 12 weeks (of date of onset of cough)
Type of Specimen	Throat swab	Nasopharyngeal swab	Serum
Number	2	2	1
Transport Media	Amies transport media	Regan-Lowe/Amies transport media with charcoal	Not required for serum
Storage & Transportation	2-8°C	2-8°C	2-8°C

For further details, refer to Surveillance for Diphtheria, Pertussis and Neonatal Tetanus, Field Guide 2020 New Delhi: MoHFW; 2020 https://www.mohfw-dohfw.gov.in/static/uploads/2025/12/f9a10a306530dafba339ed23cade6a98.pdf

Figure 6: *Workflow of DPT Case Investigation*



14. VSIMS Portal for VPD Surveillance

The Vaccine-Preventable Diseases Surveillance Information Management System (VSIMS) is the national platform for case-based surveillance of vaccine-preventable diseases (VPDs). It integrates reporting, case investigation, sample collaction, laboratory confirmation, and program monitoring into a single digital system. District Surveillance Officers (DSOs), Medical Officers, laboratory personnel, and program managers are expected to use VSIMS as the primary tool for recording, managing, and analyzing VPD surveillance data *(Figure 7)*.

1. **VSIMS User Access and Roles**

    - Users must log in with their authorized credentials. Role-based access ensures that each user only sees the data relevant to their responsibilities.

    a. District Level

    - Enter suspected VPD case details in the physical Case Investigation Forms (i.e. CIFs for each suspected Polio, Measles, Rubella, Diphtheria, Pertussis, NNT case).

    b. District Surveillance Officer (DSO)

    - Enter details of CIFs in VSIMS, and ensure its correctness and completeness.
    - Track specimen collection, transportation, and results from WHO Accredited Laboratories.

    c. Laboratory Staff

    - Enter test results directly into VSIMS.
    - Update sample receipt date, specimen quality/ and result date into VSIMS.

    d. State Surveillance Officer (SSO)/Program Managers

    - Generate and review district-level reports.
    - Review the indicators and linelist for district performance and quality of data.
    - Monitor trends of VPD surveillance and laboratory performance.

    e. National level

    - Provide technical oversight in compliance with national and global standards for each VPDs.
    - Manage overall data, access system-wide dashboards, ensure quality standards, and maintain server functions.

2. **Data Entry Flow**

   a. **Case Detection & Notification**

      i Enter suspected case details (demographics, onset date, clinical symptoms, travel history, vaccination history, etc) in VSIMS within 24–48 hours of investigation and before sending specimens to laboratory for testing.

      ii System auto-generates an EPID number (unique identifier), except the last 3 digit of case number. The last 3 digit has to be given manually, in chronological order to the previous given number.

   b. **Case Investigation Form (CIF)**

      i Complete all mandatory fields in CIF, including demographic, clinical, and immunization details, travel history etc.

      ii CIF Quality Tracker shows % completeness of data entry to avoid incomplete forms.

      iii Auto-filled details (e.g., district, block, health facility) reduce errors

      iv Link to Laboratory Request Form (LRF) if specimens are collected.

      v Sending the system-generated LRFs along with specimen for testing is mandatory

   c. **Specimen Collection & Laboratory Data**

      i Record specimen type, date, and transport details.

      ii Delete option in VSIMS is disabled once the lab receives the sample, ensuring data integrity.

      ii Laboratory staff to upload test results, which are automatically linked to case record.

   d. **Follow-Up Tracking**

      i AFP: 60-day follow-up for inadequate cases and cases with vaccine virus or VDPV or wild poliovirus. ERC documentation need to be completed and submitted at national level for ERC meeting and case classification.

      ii MR: 30-day follow-up (can be done telephonic).

      iii DPT/PTS/NNT: 60-day follow up (can be done telephonic).

      iv VSIMS tracks pending follow-ups

   e. **Outbreak Reporting**

      i MR Outbreak Module: Generates outbreak ID automatically.

      ii Captures notification, investigation, sample collection, shipment, laboratory results, outbreak response immunization (ORI), and RI intensification details.

f. Active Case Search (ACS) Data

i CIF have separate section for recording ACS data: record type, date, and results of ACS in community.

ii Record missed cases and report to DSO

g. Case Classification

i Based on laboratory results and algorithms, cases are classified as confirmed, discarded, or pending

h. Reports for Monitoring

i AFP Analysis Reports: Summary indicators, AFP Line-list, 60-day follow-up tracking, iVDPV line-list.

ii MR Analysis Reports: Summary indicators, MR Line-list, Outbreak summary, pending 30 day follow-up.

iii DPT Reports: Summary indicators, Linelist, pending 60 day follow-up.

iv Performance of Reporting Sites: Tracks performance of reporting sites (part of network and not part of network) in terms of Active case search and case reporting.

3. VPD Surveillance Reporting Forms*

a. Health facility level

i VPD-H002: Weekly Hospital report (to be completed by all reporting units (RUs) and submit to District every Monday. If no case, Zero report need to be submitted. Weekly cases to be included as per surveillance calendar.

ii VPD-H003, VPD-H003A: Hospital Active Surveillance Form (for RU hospitals) – to be submitted every Monday

b. District level

i VPD-D001: District weekly VPD report (to be completed and sent to State every Tuesday)

ii VPD-D002: Summary timeliness & completeness of weekly reports (Quarterly) – to be prepared by the district and share with State every quarterly.

iii VPD-D003: Active case search at Reporting sites (RU & Informers) – details of ACS to reporting sites to be captured in this form and enter in VSIMS.

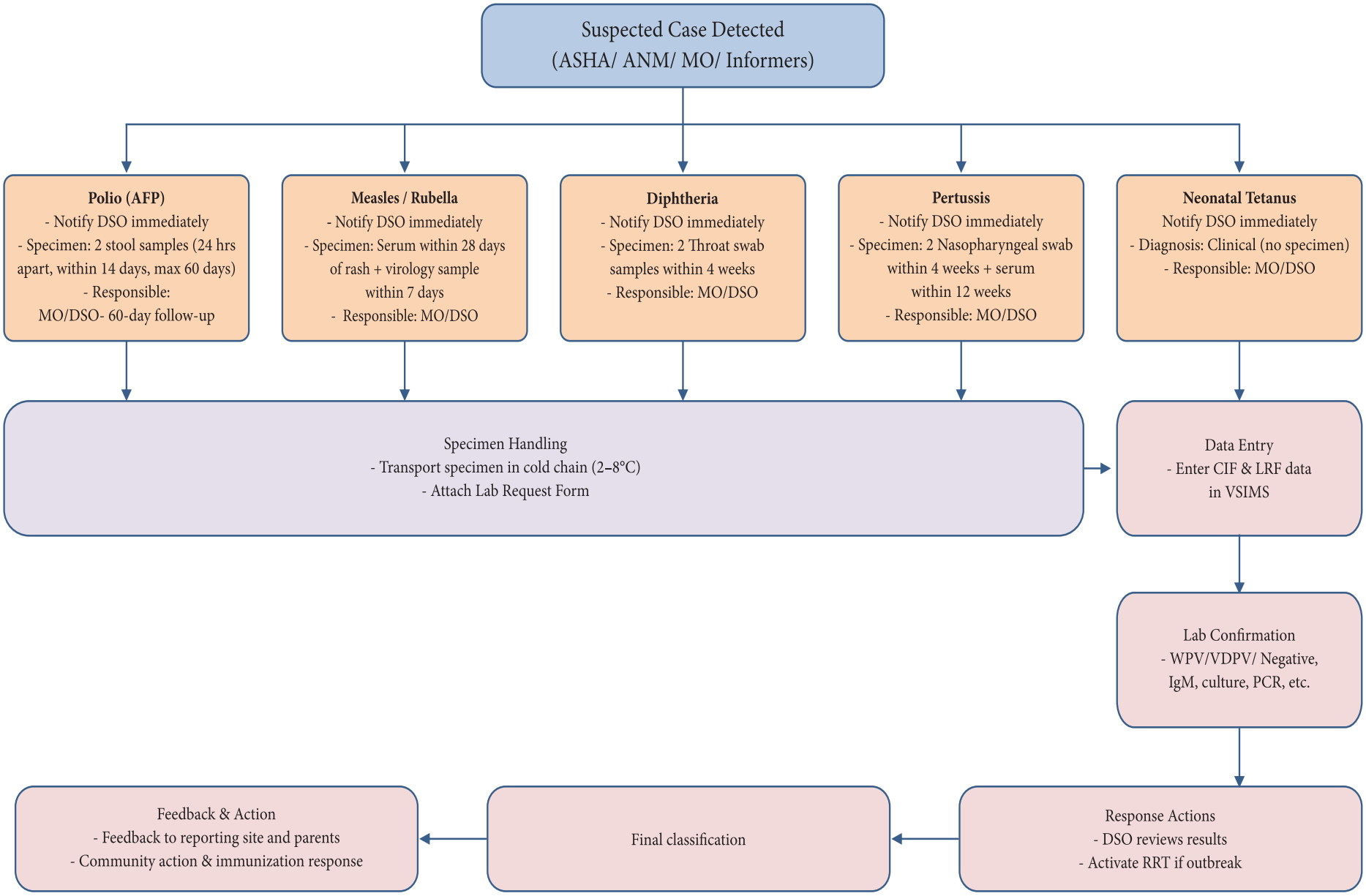
c. State prepare & share with National level:

i VPD-S001 (weekly) - to be completed by State and submit to National level every Wednesday.

ii VPD-S002 (quarterly) - to be completed by State and submit to National level every quarterly.

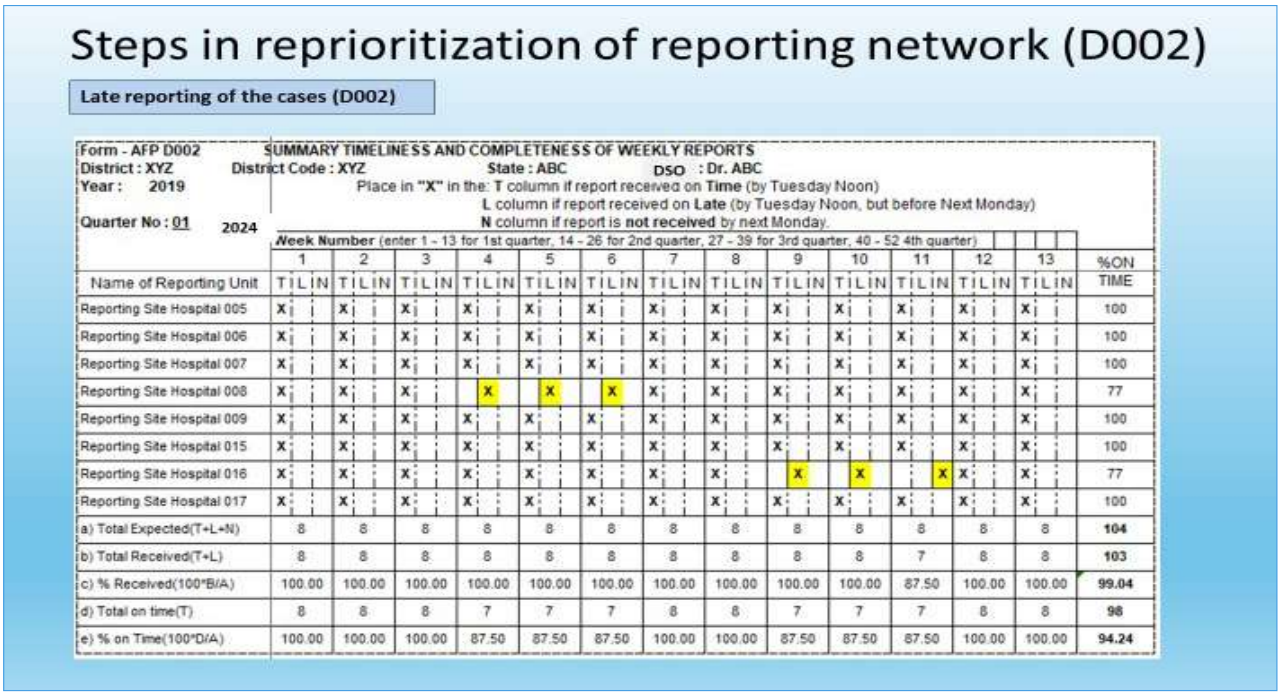
**VPD Surveillance Reporting Forms and CIFs attached as Annexure VI*

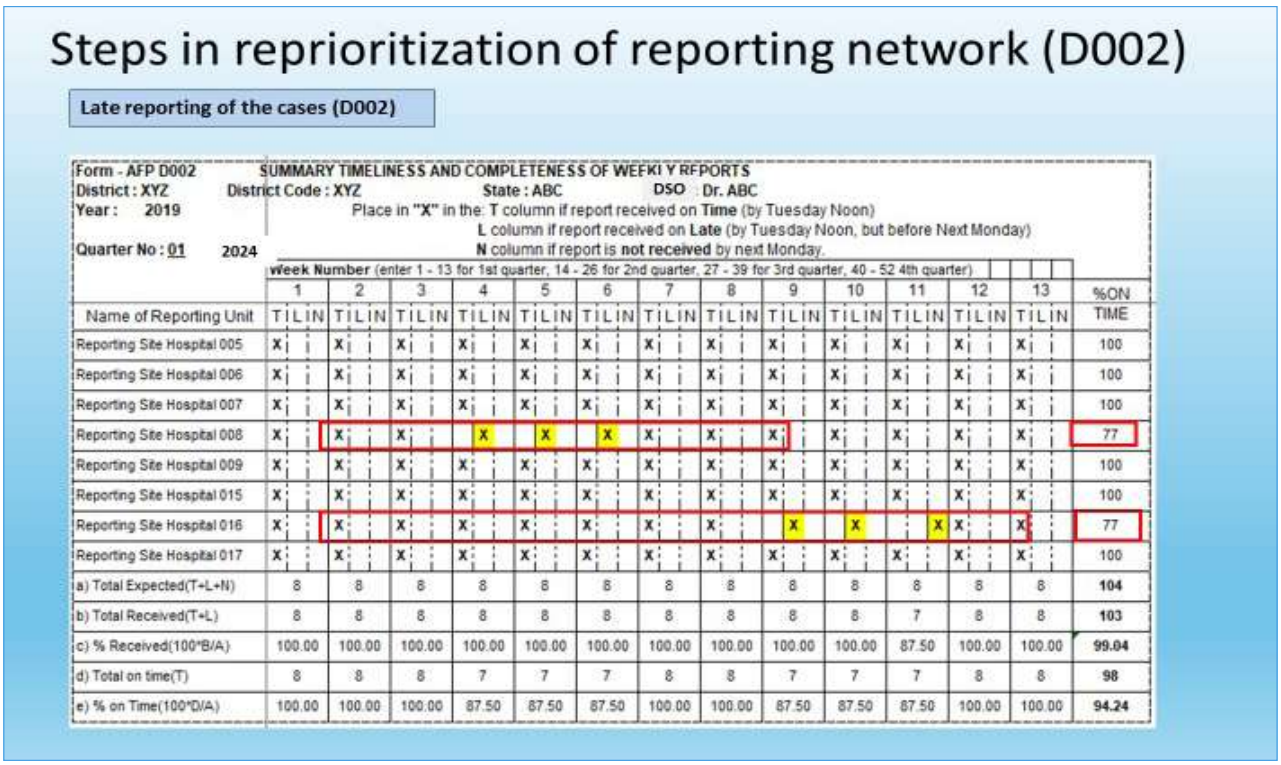
Figure 7: *Flow of Information in State/s with COMPLETE Transition*

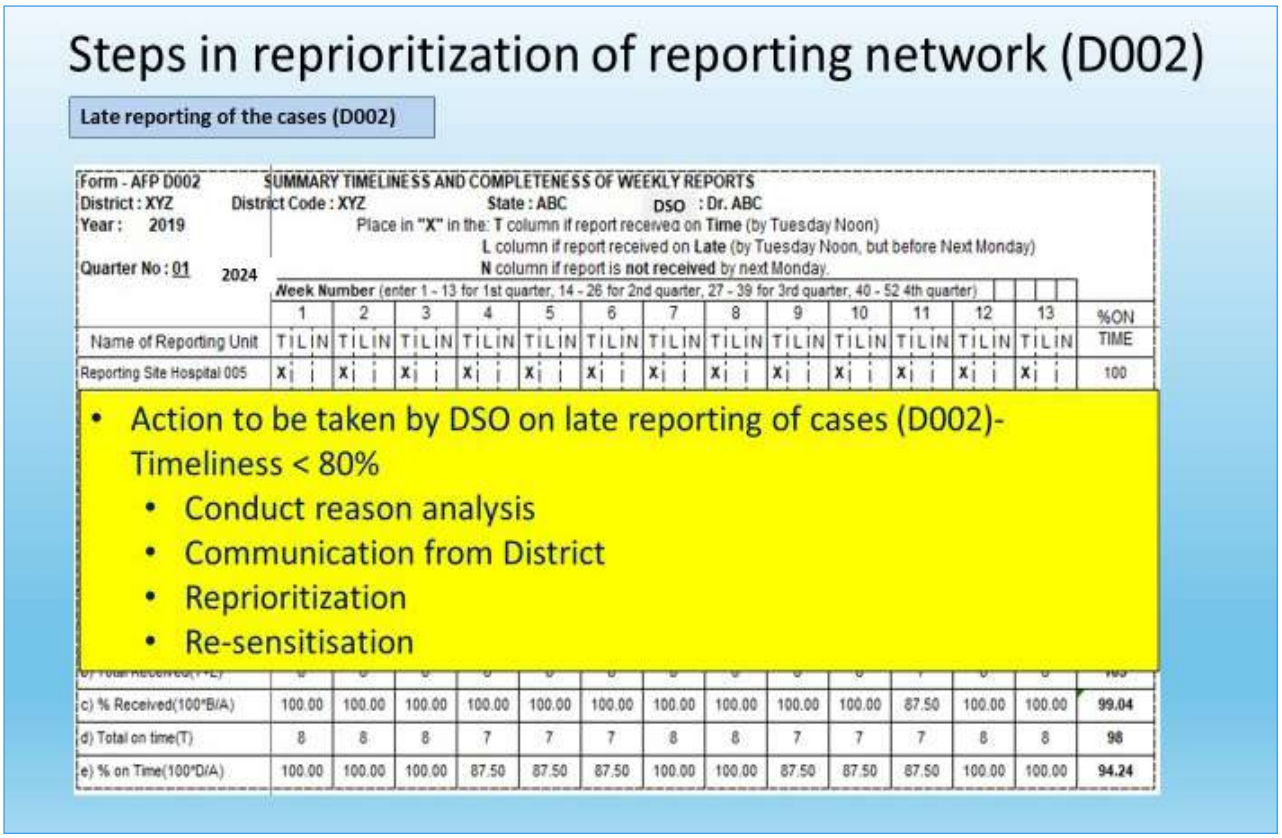


4. **Steps in reprioritization of reporting network** - DSO to review the VSIMS Portal data for entries filled/ vacant for each reporting site, i.e Active case search and missed / reported cases. The Health Facility Contact Analysis (HFCA) from VSIMS reports and CIFs shall also be analysed. DSO should also review the quarterly surveillance reports (D002) for reprioritization. All these data shall be utilized to add new reporting site, reprioritize RS from LP to HP and HP to LP, make new VHP RS, deletion of RS, etc. The analysis shall also help in deciding prioritization of visits to reporting sites. The example of reviewing quarterly report (D002) is given in *Figure 8 - 10.*

Figure 8, 9 & 10: *Steps in Reprioritization of Reporting Network (D002)*







5. Key Features for VSIMS Users

a. Validation checks: For main fields the system flags incomplete or incorrect entries (e.g., wrong date formats, missing fields).

b. Auto-save: Prevents data loss during connectivity issues.

c. CIF Completeness Tracker: Allows supervisors to monitor missing or incomplete information.

d. Cross-Notification: If a case is reported in one district but resides in another, the system auto-forwards the record after confirmation from the investigating officer.

e. Printable Forms: CIFs and Laboratory Request Forms (LRFs) can be printed directly for field use.

f. Reports: Users can view real-time indicators (AFP rate, stool adequacy, Non-Measles Non-Rubella discard rate, specimen turnaround time).

g. When Date of Birth (DOB) of case is entered in VSIMS, the years, months, days will be auto calculated and vice-versa

6. Common Errors to Avoid

a. Wrong district selection → incorrect EPID numbers.

b. Wrong lab selection → delays in specimen testing.

c. Incomplete CIF sections → leads to low data quality score.

d. Incorrect case numbering – only helpdesk can correct

7. Common Challenges & Solutions

a. Login/Password Issues → Contact State focal point (State Surveillance Officer (SSO) with copy to CSU, IDSP, NCDC, and VSIMS Helpdesk at Delhi

b. Slow Performance → Check internet bandwidth; retry during off-peak hours.

c. Data Entry Errors → Recheck formats (DD/MM/YYYY, numeric fields).

d. Missing Lab Results → Confirm entry by lab; allow 24 hrs for synchronization. Escalate unresolved issues to the State Surveillance Officer, and WHO SMO (Transition), and further to VSIMS Helpdesk (WHO) at Delhi (if required)

8. Practical Tips for DSOs/SSOs

a. Always verify district and lab before final submission.

b. Use auto-save and reset buttons to avoid losing work.

c. Track pending stool/follow-up requests under the "Requests" menu (Request menu is only for tracking 60-day follow up and stool sample collection requests of AFP cases received from other districts/Users).

d. Regularly generate indicator reports to present in DTFI/STFI meetings.

e. Use the search and filter functions to quickly retrieve old cases

9. Reporting Timelines

a. Case detection → Entry in VSIMS: within 24–48 hrs. of case investigation and before sending the samples to the laboratory for testing.

b. Specimen collection: AFP (within 14 days (adequate sample) , and maximum till 60 days from onset of paralysis); MR (Virology: within 7 days, Serology within 28 days of rash onset).

c. Specimen transport to lab: within 72 hrs, under adequate cold chain and proper documentation (LRF).

d. Lab results entry by the laboratories: as soon as the results are available.

e. Zero reporting: every week (on Monday) from all reporting units.

f. Follow-up: AFP and DPT – 60 days from onset; MR – 30 days from onset

g. Follow-up data entry: as soon as the follow up is done.

10. Best Practices

a. Enter data promptly (immediately after case investigation).

b. Ensure zero-reporting every week without fail, even if there are no cases in that week.

c. Always complete all mandatory fields in CIF/LRF.

d. Regularly use indicators reports for monitoring before DTFI/STFI meetings.

e. Log out after use to maintain data security.

f. Periodically clear browser cache for smooth system performance *(Table 13)*.

Table 13: *Do's and Don'ts for VSIMS Usage*

Do's	Don'ts
Enter suspected VPD case details immediately after case investigation to generate LRF	CIFs or LRFs not to be partially filled/incomplete-lowers data quality scores
Always complete all mandatory CIF and LRF fields before saving	Do not delay data entry, otherwise laboratories will receive samples and case details late and reporting of results will be delayed – fill CIF details in VSIMS as soon as case is investigated
Verify district, block, health facility, and lab selection before submission	Do not select the wrong district/lab, as EPID and case linkage errors cannot be edited locally
Track pending follow-ups (AFP and DPT – 60 days, MR – 30 days)	Do not share your login credentials with anyone
Use indicator reports for reviews in DTFI/STFI	Do not ignore system alerts

15. Standard Operating Procedures (SOPs) for Record Keeping/ Discard of AFP / MR Surveillance Documents

Surveillance involves the ongoing and systematic collection, analysis, interpretation, and dissemination of data about cases of a disease and is used as a basis for planning, implementing, and evaluating disease prevention and control activities. Various documents related to each of these components are regularly being maintained at state level *(Table 14)* and national levels *(Table 15)*.

Table 14: *Schedule for Storage/ Disposal of Surveillance Documents at DSO/DIO Level*

S. No.	Name of Surveillance Document	Duration of Retention of Physical (years)	Soft Copy Storage Required (Yes/No)
1.	Line list of reporting sites	5	Yes-Excel
2.	Line list of AFP and MR cases	5	Yes-Excel
3.	CIFs of VPDs under surveillance (AFP, MR, DPT)	5	Yes (scanned copies)
4.	Notification registers	4	No
5.	Lab specimen tracking register	4	No
6.	Lab request forms	5	Yes (scanned copies)
7.	ERC documentation	4	Yes
8.	Rejection case CIF	4	No
9.	Copies of VPD case investigation feedback shared with parents and RS	4	Yes
10.	Advance workplan for conducting ACS, data analysis, workup of cases, training workshops etc.	4	No
11.	Copies of weekly district reports sent to state (VPD-D001)	5	No
12.	Summary, timeliness & completeness of district reports (VPD-D002) sent to state quarterly	5	Yes-Excel sheet
13.	Weekly Zero reports received from the reporting units (VPD-H002)	5	Yes-Excel sheet

S. No.	Name of Surveillance Document	Duration of Retention of Physical (years)	Soft Copy Storage Required (Yes/No)
14.	Active surveillance form (VPD-D003) filled by the DSO/DIO and shared with state quarterly	5	Yes-VSIMS
15.	Active search forms received biannually from small/ large reporting units (VPD-H003/ VPD-H003A)	5	Yes-Excel sheet
16.	Documentation of periodic data analysis (at least monthly)	4	No
17.	Presentation copy of previous training workshop conducted for VPD surveillance	4	Yes
18.	Maps-spot maps of RS and AFP-FR cases	4	Yes
19.	Letters/documents sent by the district to blocks/ reporting units to improve VPD surveillance	5	Yes
20.	Meeting minutes related to VPD surveillance	5	Yes

Table 15: *Schedule for Storage/Disposal of Surveillance Documents at National level*

S. No.	Name of surveillance document	Duration to be retained (years)	Scanning and server backup required (Yes/ No)
1.	ERC documents (Compatibles, discard, ERC Rejection)	4	Yes
2.	Rejection documents	4	No
3.	ERC/Rejection Meeting reports	4	Yes
4.	ERC meeting letters	4	Yes

With gradual transitioning of surveillance management systems from paper-based to online database, we need to develop a protocol for time-based record-keeping of the important/ essential documents while appropriately discarding those which are no longer required *(Table 16)*.

1. **Storage and Security** - It is suggested that DSO must ensure to obtain all the previous records from WHO SMO office of VPD surveillance and keep them in safe custody at the office of DSO.

    a. A dedicated server should be used for storage of scanned and soft copies of the documents and data as per the details above.

b. Records must be stored securely to prevent damage, loss, or unauthorized access.

c. Use both physical (file cabinets, archive rooms) and digital formats (scanned copies, databases) with backup.

d. Records should be protected against damage (fire, water, pests) and unauthorized access.

e. Maintain cold chain and sample transport logs to demonstrate specimen integrity.

f. Ensure accessibility for audits and certification teams.

2. Disposal

a. Records may be securely disposed of only after completion of the retention period unless under active investigation or audit.

b. Physical records should be shredded or incinerated; electronic records should be permanently deleted from all storage media.

c. Disposal must be documented with date and authorized personnel signature.

3. Responsibility

a. District Surveillance Officers (DSOs) and State Surveillance Officers (SSOs) are responsible for ensuring compliance with retention guidelines.

b. Regular monitoring and supervision should be conducted by State and District Surveillance Officers to verify proper record keeping.

4. Monitoring & Compliance

a. Non-compliance issues must be addressed immediately with corrective actions.

b. Training on proper record management shall be included in annual capacity building programs.

Table 16: *Criteria for Assessment of Surveillance Records*

Parameter	Good Reporting	Optimal Reporting
Completeness of Records	≥ 90% of case investigation forms and line listings complete	100% complete and properly filed for all suspected/ confirmed cases
Timeliness of investigation	≥ 80% of cases investigated within required timeframe: AFP – 48 hrs Measles/Rubella – 24-48 hrs DPT– within 24-48 hrs	≥ 95% of cases investigated within stipulated timeframe
Sample Adequacy & Collection	≥ 80% of suspected cases with adequate, correctly collected samples: AFP – 2 stool samples Measles/Rubella – serum + throat swab/NPS/ urine sample Diphtheria – throat swab Pertussis – nasopharyngeal swab + Serum Neonatal Tetanus – None	≥ 90% of suspected cases with timely and adequate sample collection
Laboratory Feedback	≥ 80% of samples processed and lab results communicated within standard turnaround time	100% samples processed and results provided timely
Zero Reporting Compliance	≥ 80% reporting units submit Zero reports even when no cases detected	100% consistent zero reporting without missing reports
Outbreak Investigation	All suspected outbreaks detailed investigated after preliminary investigation carried out within 48-72 hours; reports filed	Immediate outbreak investigation initiated with documented response
Data Accuracy & Consistency	Minimal errors; cross-checked data consistent across forms and registers	No discrepancies; data verified and validated for accuracy
Storage & Security of Records	Records securely stored with controlled access; digital backups maintained	Organized, secure storage; easy accessibility for audits
Training & Capacity Building	≥ 80% surveillance staff trained on record-keeping and reporting annually	100% surveillance staff regularly trained and supervised
Surveillance Sensitivity Indicators	Polio: Non-polio AFP rate ≥ 2/100,000 children under 15 years of age Measles/Rubella: NMNR discard rate ≥ 2/100,000 population Others: suspected cases identified as per expected incidence	Surveillance sensitivity meets or exceeds national and Global targets

- Timeliness differs by disease but rapid notification and sample collection are critical for all.
- Sample adequacy ensures laboratory confirmation is possible and reliable.
- Zero reporting prevents surveillance blind spots.
- Surveillance sensitivity is a key performance indicator demonstrating active and effective case finding.
- Records should be used actively for decision-making, outbreak response, and program improvement.

16. VPD Surveillance: Performance Indicators and Targets

Robust performance monitoring is central to an effective VPD surveillance. This section outlines the key indicators and targets established for AFP *(Table 17),* iVDPV *(Table 18)*, Measles-Rubella *(Table 19)*, Diphtheria-Pertussis-Neonatal Tetanus, *(Table 20)* spanning case detection, timely notification, sample adequacy, laboratory performance, and data quality. Regular assessment against these benchmarks *(Table 21 and 22)* enables surveillance officers at district, state, and national levels to identify gaps, drive corrective action, and ensure that surveillance is at par with the global standards.

Table 17: *AFP Surveillance Performance Indicators & Targets*

S. No.	AFP Surveillance: Performance Indicators	Targets
1.	Non-Polio AFP Rate	≥ 2
2.	AFP Rate	≥ 2
3.	Stool Adequacy Rate	≥ 80%
4.	Non-Polio Enterovirus (NPEV) Detection Rate	≥ 10%
5.	Timeliness of weekly- 'zero' reporting	≥ 80%
6.	Reported cases investigated < 48 hours of reporting	≥ 80%
7.	Stool specimens received at the national laboratory < 3 days of being sent	≥ 80%
8.	Specimens arriving at the laboratory in good condition*	≥ 80%
9.	Specimens with a turn-around time < 14 days	≥ 80%
10.	60 days follow up of AFP cases to verify presence of residual paralysis or weakness	≥ 80%

**Good condition means that upon arrival: there are frozen ice packs or ice, or a temperature indicator (showing < 8° C) in the container; the specimen volume is adequate (> 8 grams); there is no evidence of leakage or desiccation; and appropriate documentation (laboratory request/reporting form) is completed.*

Table 18: *iVDPV Surveillance Performance Indicators & Targets*

S. No.	iVDPV Surveillance Performance Indicators	Targets
1.	Percentage of PID patients with poliovirus excretion for whom a detailed case investigation (with contact tracing and community assessment) is conducted within 48 hrs of laboratory results.	≥80%
2.	Percentage of specimens arriving at a WHO-accredited laboratory within 3 days of collection.	≥80%
3.	Percentage of stool specimens for which laboratory results are sent to sentinel facility/submitting agencies within a defined period: - within 14 days of specimen receipt for poliovirus isolation. - within 7 days of isolate receipt for intratypic differentiation. - within 7 days of intratypic differentiation for sequencing results.	≥80%
4.	Percentage of follow-up specimens collected out of expected.	≥90%
5.	Number of active surveillance visits implemented out of planned.	≥80%

Table 19: *MR Surveillance: Performance Indicators & Targets*

S. No.	MR Surveillance Performance Indicators	Targets
1.	Non-measles non-rubella discard rate per 100,000 total population	≥ 2
2.	Proportion of second administrative level units reporting at least two non-measles non-rubella cases per 100,000 population	≥ 80%
3.	Proportion of surveillance units sending measles and rubella reports, 'zero-case reporting' to the national level on time ≥ 80%	≥ 80%
4.	Proportion of suspected cases investigated within 48 hours of notification	≥ 80%
5.	Proportion of suspected cases with adequate serum specimen collection	≥ 80%
6.	Proportion of eligible suspected cases with adequate virology specimen collection	≥ 80%
7.	Proportion of specimens received in the lab within 5 days of collection	≥ 80%
8.	Proportion of serology results reported by the laboratory within 4 days of specimen receipt	≥ 80%
9.	% of MR Outbreak investigation	100%

Table 20: *DPT Surveillance: Performance Indicators & Targets*

S. No.	DPT Surveillance Performance Indicators	Targets
1.	Proportion of cases with timely notification	≥ 80%
1.1	Diphtheria cases ≤ 7 days of onset	≥ 80%
1.2	Pertussis cases ≤ 4 weeks of onset	≥ 80%
1.3	Neonatal Tetanus cases ≤ 7 days of onset	≥ 80%
2.	Proportion of timely investigation (within 48 hrs. of notification)	≥ 80%
3.	Proportion of cases with adequate sample collection	≥ 80%
4.	Proportion of timely Active Case Searches in the community (within 7 days of case investigation)	≥ 80%

Table 21: *Parameters & Levels for Monitoring and Evaluation of VPD Surveillance in India*

Parameter	Description	National Level	State Level	District Level
Surveillance Sensitivity	Ability to detect cases; measured by non-polio AFP rate (polio), discard rates (measles/rubella)	≥2 non-polio AFP cases/100,000 <15 yrs Non-Measles Non-Rubella discard rate ≥2/100,000	Same as national, disaggregated by districts	≥2 non-polio AFP cases /100,000 <15 yrs; Non-Measles Non-Rubella discard rate ≥2/100,000
Timeliness of Case Notification	Time between symptom onset and notification	≥80% cases notified within 10 days of onset (AFP); 24 hrs (MR)	Same with district-wise breakdown	Monitor cases notified within stipulated time
Completeness of Case Investigation	Percentage of cases investigated within 48 hrs	≥80% complete investigations	≥80% completion	≥80% completion
Adequacy of Sample Collection	Stool samples for AFP; serum for MR; swabs for MR/diphtheria/pertussis	≥80% cases with adequate samples	≥80% adequacy	≥80% adequacy
Laboratory Performance	Proportion of samples processed within standard time	≥80% of stool samples tested within 14 days, MR Serum samples within 4 days	Timely feedback from designated labs	Samples transported and tested timely
Non-Polio Enterovirus Rate (for Polio)	% stool specimens positive for non-polio enteroviruses (indicates sample quality)	≥10% recommended	Monitored to ensure good sample quality	≥10% rate desirable
Timeliness of weekly - 'zero' reporting	Reporting by all reporting units even if zero cases	≥80% compliance	≥80% compliance	≥80% compliance
Outbreak Detection & Response Time	Time taken to detect and respond to outbreaks	Response within 72 hrs	Rapid response teams activated	Investigations initiated within 72 hrs
Training & Capacity Building	Percentage of surveillance staff trained annually	≥80% staff trained	Training coverage monitored	Regular refresher trainings
Data Quality & Reporting	Accuracy, timeliness, and completeness of reports	Monthly/weekly/quarterly data submitted on time	District/State reviews for data quality	Facility-level reporting accuracy
Cold Chain & Sample Transport	Proper maintenance of cold chain during sample transport	Regular monitoring	Regular monitoring	Functioning sample transport with proper cold chain within 72hrs

Table 22: *Monitoring Framework Post Transfer of VPD Surveillance Activities to IDSP*

Variables	AFP surveillance	FR surveillance	Diphtheria	Pertussis	Neonatal tetanus	Environmental surveillance	iVDPV surveillance
Case number	Number of AFP case	Number of FR case	Number of DTH cases	Number of PTS cases	Number of NNT cases	Number of samples collected	Number of PID cases
Data entry	% CIF being entered in VSIMS within 2 days of case investigation						% CIF being entered in VSIMS within 2 days of case investigation
	% CIF with >80% cells filled						% CIF with >80% cells filled
	No or incorrect mobile number						No or incorrect mobile number
	% cases verified by DSO						
Cardinal Indicator	AFP rate	NMNR discard rate					
	NPAFP rate						
	% Timely notification		% Timely notification				
	% Timely investigation						
Key indicators related to sample	% Stool adequacy	% serology sample collected	% throat swab sample collected	% NPS sample collected		% sample collected against the expected number	% new cases with two samples collected
	% NPEV isolation	% virology sample collected		% serology sample collected		% samples with NPEV+SL isolation >50%	% cases where follow-up sample to be collected
	% samples reached in lab within 5 days of sample collection 1	% serology samples reached in lab within 5 days of collection	% throat swab samples reached in lab within 5 days of collection	% NPS samples reached in lab within 5 days of collection		% ES samples reached in lab within 5 days of collection	% samples reached in lab within 5 days of sample collection
	% samples reached in lab within 3 days of sample collection 2	% virology samples reached in lab within 5 days of collection		% serology samples reached in lab within 5 days of collection			

Table 22: *Monitoring Framework Post Transfer of VPD Surveillance Activities to IDSP contd.*

Variables	AFP surveillance	FR surveillance	Diphtheria	Pertussis	Neonatal tetanus	Environmental surveillance	iVDPV surveillance
	% Samples reached in lab in good condition					% Samples reached in lab in good condition	
Other surveillance process	Number of Cross notified IN cases						
	Number of Cross notified OUT cases						
	Number of cases pending for follow-up						
	Number of cases pending for ERC document						
	Number of double reported case						
	Number of Rejected case						
Outbreak		Number of measles outbreaks flagged	Number of cases with Public Health Response		Number of cases with community search		
		Number of outbreak with preliminary investigation within 72 hours					
		Number of outbreak with Vit A supplementation					
		Number of lab confirmed outbreak with ORI done					
		Number of lab confirmed outbreak with root cause analysis done					

Table 22: *Monitoring Framework Post Transfer of VPD Surveillance Activities to IDSP contd.*

Variables	AFP surveillance	FR surveillance	Diphtheria	Pertussis	Neonatal tetanus	Environmental surveillance	iVDPV surveillance
		Number of outbreaks with summary of outbreak (OB 004) available					
Passive surveillance	Number of RU						
	% Timeliness						
Active surveillance	Number of VHP						
	Number of ACS at VHP						
	Number of HP						
	Number of ACS at HP						
	Number of LP						
	Number of ACS at LP						
	Number of telephonic ACS						
Workshops	Number of district level workshop done						
	Number of block level workshop done						
Program review	Number of STFI/ DTFI done						
	Number of DWR meeting done						

ANNEXURE I

Office Order for constitution of Oversight Committee and Joint Working Group

एक कदम स्वच्छता की ओर

संख्या Z.21011/1/2016-PRC(NCDC)/(8323282) /937
भारत सरकार
Government of India
राष्ट्रीय रोग नियंत्रण केन्द्र
National Centre for Disease Control
(स्वास्थ्य सेवा महानिदेशालय)
(Directorate General of Health Services)
22-शाम नाथ मार्ग, दिल्ली - 110 054
22-Sham Nath Marg, Delhi -110 054

दिनांक: 21.04.2025

OFFICE ORDER

With the approval of Director, NCDC, an oversight Committee has been constituted to monitor the progress of Transition of VPD surveillance activities and to assess the readiness of the government system, mentioned as under:

1.	Dr. R P Joshi, Additional DGHS	Chairperson
2.	Director NCDC	Member Secretary
3.	Dr. L Swasticharan, (representative from DteGHS)	Member
4.	Representative from NHM Finance, to be nominated	Member
5.	Dr. Pawan Kumar, Additional Commissioner, Immunization	Member
6.	Dr. N K Arora, NCCPE	Member
7.	Dr. Himanshu Chauhan, Joint Director & HoD (IDSP)	Co-opted Member

(प्रकाश डोवाल)
सहायक निदेशक (प्रशासन)

To:
All Officers concerned.

Copy to:
1. Additional Director & HoD (Admin./Finance).
2. Additional Director & HoD (PBA).
3. AO (BK).
4. AO (JM).
5. AL&IO.
6. Store Officer.
7. PS to Director.

संख्या Z.-21020/01/2025-PH (8313708)
भारत सरकार
Government of India
राष्ट्रीय रोग नियंत्रण केन्द्र
National Centre for Disease Control
(स्वास्थ्य सेवा महानिदेशालय)
(Directorate General of Health Services)
22-शाम नाथ मार्ग, दिल्ली - 110 054
22-Sham Nath Marg, Delhi -110 054

दिनांक: **18.02.2026**

कार्यालय आदेश/ OFFICE ORDER

A Joint Working Group (JWG) was constituted (**Office Order dated 27.03.2025**) under the Chairmanship of Director, NCDC to strengthen Vaccine Preventable Disease surveillance in country and to work out the modalities to integrate it with IDSP-IHIP in phased manner. The revised list of JWG members is as under:

1.	Director, NCDC	Chairperson
2.	Addl. Dir. & HoD, Epid Division, NCDC	Member
3.	Director, AIIH&PH, Kolkata	Member
4.	DDG, DM Cell, MoHFW	Member
5.	National Team Lead, NPSN	Member
6.	Deputy Commissioner, Immunization	Member
7.	HoD, Enterovirus Division, NCDC	Member
8.	HoD, IDSP	Member Secretary
9.	**Other Co-opted Members:** 1. State Surveillance Officer, Uttar Pradesh 2. State Surveillance Officer, Bihar 3. State Surveillance Officer, Telangana 4. State Surveillance Officer, Assam 5. State Surveillance Officer, Gujarat 6. State Surveillance Officer, Madhya Pradesh	Members
10.	Any other co-opted members (as decided by Chairman)	Member

This issues with the approval of Director, NCDC, Delhi.

(Prakash Doval)
Assistant Director (Admin.)

To,

All Concerned Officers

Copy to: -

1. PSO to DGHS.
2. PPS to AS (PH), Kartavya Bhawan, MoHFW, New Delhi.
3. PS to Director, NCDC.
4. Additional Director & HoD (Admin. - Finance), NCDC, Delhi.
5. Joint Director & HoD (PBA), NCDC, Delhi.
6. DDO
7. AO (BK)/ AO (JM)

ANNEXURE II

Role of Healthcare Officials and workers in VPD Surveillance

1. ASHA

- To be well versed in case definitions of VPDs and their reporting through IDSP Community Reporting Tool
- Urgent notification of any suspected AFP/VPD case in her area to the DSO
- Ensure the mobile number of DSO is displayed in all informer units (if present) within her area.
- Visit or assist the Medical Officer in visiting the informer units (quacks or temples or polio doctors) in her area and update them regarding the case definition
- Provide regular feedback of the reported cases to the informer units.
- Assist in sample collection process especially during VPD investigation.

2. ANM/CHO

- Notify all the AFP/VPD cases in her/his area to the DSO on immediate basis
- Ensure the number of DSO to be displayed in all informer sites (if present) within her area.
- Assist in sample collection process especially during AFP surveillance and also assist in maintaining the cold chain and reverse cold chain of the sample collected till the shipment wherever required.
- Conduct/assist in conducting visits to High priority and Very High Priority private informer units within his/her area.
- Visit or assist in visiting the quacks or temples or polio doctors in her area and update them regarding the case definition.
- Provide regular feedback of the reported cases to all the reporting sites under her/him.
- Ensure ASHAs/CHOs are well versed with the case definition of each VPDs

3. Medical Officer

- Each medical officer to undergo training and retraining on VPD surveillance.
- To keep oneself updated with the latest VPD case definitions, the forms to be filled, processes with respect to sample collection, shipment, storage and transportation.
- To initiate VPD case investigation and complete the same in a time bound manner
- Timely filling up of case investigation forms, follow up activities like 30 days and 60 days.
- Responsible for maintaining the VPD indicator norms within his jurisdiction like case detection (based on population norms), timelines, sample collection procedures (including types of samples).
- Should have a regular communication with all the reporting sites within his/her jurisdiction and also suggest District Surveillance Officer for any addition or deletion of reporting sites within his/her jurisdiction.

- Conduct site visit to detect unreported cases active case searches within all the reporting sites under him/her as per norms.
- Build capacity of all staff like ASHA, ANM, CHO posted under the PHC/CHC.
- He would be responsible for maintaining and providing support for maintenance of adequate cold chain or reverse cold chain wherever required within his jurisdiction for the VPD surveillance activities.
- Conduct regular meetings with all his ANMs/CHO/ASHAs to review the VPD surveillance activities and also provide regular feedback.

4. Taluka Health Officer/Block Medical Officer

- Create communication network of all the ASHAs / ANMS / Medical Officers of the district for VPD surveillance
- Orientation or build capacity for sharing of information by his/her subordinates on location of the case immediately by using available technologies
- Should have a regular communication with all the reporting sites within his/her jurisdiction and also suggest District Surveillance Officer for any addition or deletion of reporting sites within his/her jurisdiction.

5. District Surveillance Officer

- Assigning investigating officer to each case of VPD notified
- Ensure data entry on VSIMS portal for each VPD case
- Coordinate Joint investigation of VPD outbreaks with immunization officials
- Monitoring the performance of VPD case investigation as per the existing benchmarks
- Ensure adequate training for all stakeholders within the District on VPD surveillance activities
- Ensure filling up of all vacant positions under IDSP to undertake surveillance of VPDs in the District
- Assess the requirement of additional resources (HR, finance, logistics etc.) and propose the same in the NHM PIP
- Maintain and update a master list of reporting sites within the District
- Maintain records of funds received and spent w.r.t VPD surveillance activities.
- Present the VPD surveillance report during the District Task Force on Immunization meetings
- Comply with all the reporting requirements.

6. State Surveillance Officer

- Oversee implementation of VPD surveillance activities across all districts in the State, ensuring adherence to national and global standards.
- Conduct and facilitate capacity building activities including trainings and orientations for health functionaries at district and sub-district levels.

- Review and monitor district wise performance of VPD surveillance indicators on a regular basis
- Participate in State Task Force for Immunization (STFI) meetings and present VPD surveillance status for further necessary actions and support
- Collect weekly reports (D001) from all districts and share S001 with CSU, IDSP, NCDC every Wednesday
- Ensure availability of logistics for sample collection - stool kits, VTM tubes, Amies tubes, serum collection kits, etc
- Ensure districts conduct timely detection, investigation, and response to VPD cases and outbreaks, including coordination with rapid response teams and collection of appropriate samples.
- Provide regular feedback and supportive supervision to District Surveillance Officers to strengthen reporting quality and timeliness.
- Ensure printing of forms and VPD posters like H002, D001, CIF, etc
- Availability of required human resources at all levels
- Availability of adequate budget for VPD surveillance activities
- Coordination with civil society organizations like IAP, IMA, etc

6. Field Monitors (FM)

Surveillance for Acute Flaccid Paralysis (AFP), Measles-Rubella (MR) and Diphtheria, Pertussis and Neonatal Tetanus (DPT)

- *Assistance for case investigation:* Inform MO/MOIC/DIO about suspected cases of AFP, measles and DPT; assist in locating their residence for facilitating case investigation and follow up as per guidelines.
- *Assistance in specimen collection:* Track collection of stool samples from AFP cases, and specimens as per recommended surveillance guidelines from measles and VPD cases. Also track their dispatch to the laboratory in proper cold chain.
- *Identification of potential informers:* Identify potential informers in the community for further evaluation and necessary inclusion in reporting network.
- *Sensitization of reporting network:* Visit low priority informers and collect information on probable AFP, suspected measles rubella and DPT cases and share the information.
- Assistance for Outbreak investigation, case search and contact tracing: Provide support for planning and monitoring of case search for suspected cases during preliminary and detailed house to house outbreak investigation, monitoring of public health response in the village/urban areas and assist in data collection.
- Verification of vaccination history for each lab confirmed Measles/Rubella/Pertussis/ Diphtheria/Tetanus case.
- *Track and monitor other surveillance related activities:* Feedback to parents and health facilities, follow up of disbursal of per diem for case investigation, reports from reporting sites, maintenance of surveillance records at reporting sites.
- *Assistance for surveillance workshop:* Support Surveillance Medical Officer/ District Immunization Officer in arranging block and sub-block level surveillance sensitization workshop.

Routine Immunization (RI) activity

- *RI Monitoring and feedback:* Monitor RI sessions, conduct community monitoring, Birth dose vaccination and Block / PU RI monitoring as per operational guidelines and standard operating procedures and provide timely monitoring feedback at appropriate level for corrective actions. This includes monitoring of special RI drives such as Mission Indradhanush, DPT/Td or other campaigns and new vaccine introductions.
- *Assist in revision of existing micro plans:* Assist with updating of micro plans at planning unit/block level to ensure completeness of micro plans for routine immunization, validate /assist in area demarcation and periodic routine immunization intensification drives such as Mission Indradhanush.
- *High Risk Areas (HRAs) Validation:* Support in validation and updation of migratory and other high-risk settlements list and their inclusion in plans for intensification of immunization and surveillance related activities.
- *Assistance in training activities:* Assist in planning, coordinating, organizing and monitoring of training activities related to routine immunization and special RI drives and provide timely feedback for midcourse correction.
- *Assistance in data collection:* Assist collection and collation of information related to routine immunization activities required to support programmatic decision-making for routine immunization strengthening.
- Identify and enlist the areas with vaccine hesitancy, vaccination compromise, low coverage pockets and the tracking of Zero dose children for their vaccination.
- Assistance in urban immunization through mapping of the session sites, missed areas, mapping of urban wards, HRA/HCS validation and inclusion of the private facilities in RI program.

Polio and Measles Supplementary Immunization Activities (SIAs)

- *Assistance in micro planning:* Provide information to facilitate updation/revision of SIA micro plans for polio, measles, or any other immunization drive. This includes the identification and inclusion of same community female/influencers in micro plans.
- *Field Validation activity:* Validation of the micro plans for SIAs in the field with special emphasis on the migratory and other high-risk settlements. Support the identification and mapping of all high-risk areas.
- *Assistance in training:* Assist in planning, coordinating, organizing and monitoring the SIA training sessions for vaccinators and supervisors and provide necessary timely feedback at appropriate level.
- *SIA Monitoring*: Monitor the preparedness and implementation of the measles and polio SIAs as per standard protocols and guidelines issued from time to time and provide timely feedback.
- *Data collection and analysis*: Assist planning units with collection and collation of coverage data after every SIA. Analyze vaccinator and supervisor tally sheets using pre-designated data analysis tools provided and share the information at appropriate level for corrective actions.

- *Event Calendar preparation*: Prepare a list of events in the block/district, and support with the placement of vaccination teams during these events, as appropriate. Regular updation of event calendar every 6 months.

Other activities

- *Covid vaccination*: Vaccination sessions and community immunization to be monitored and feedback be provided at appropriate level for corrective actions.
- Extending the monitoring and planning support during the Health Emergencies as per the collaboration of (GoI), State Government and WCO.
- In emergency situations, support in filling of LRF for timely shipment of VPD surveillance samples.
- *Attend Block Task Force / Review meetings:* Participate in block level meetings and provide information that can be used for action and share feedback to supervisor. Share relevant information and follow up on relevant actions.
- Assist in conducting surveys and research studies related to polio eradication, polio endgame strategy, measles, and rubella elimination, VPD control and routine immunization intensification as per guidelines and protocols.
- Perform any other activity as assigned by supervisor.

ANNEXURE III

List of VPD Labs

POLIO Labs

S. No.	State Name	Lab Name	Category
1.	Delhi	National Centre for Disease Control, Delhi	AFP and ES
2.	Gujarat	B.J. Medical College, Ahmedabad	AFP and ES
3.	Himanchal Pradesh	Central Research Institute, Kasauli	AFP and ES
4.	Karnataka	ICMR- National Institute of Virology, Bangalore Unit	AFP and ES
5.	Maharashtra	ICMR-National Institute of Virology-Mumbai Unit	AFP and ES
6.	Tamil Nadu	King Institute of Preventive Medicine & Research, Chennai	AFP and ES
7.	Uttar Pradesh	Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow	AFP and ES
8.	West Bengal	Institute of Serology, Kolkata	AFP and ES
9.	Bihar	All India Institute of Medical Science (AIIMS), Patna	Sewage concentration laboratory
10.	Telangana	Institute of Preventive Medicine, Hyderabad	Sewage concentration laboratory

MR labs

S. No.	State Name	Lab Name
1.	Andaman and Nicobar Islands	Regional Medical Research Centre (RMRC), Port Blair
2.	Andhra Pradesh	Sidhartha Medical College (SMC), Vijayawada
3.	Andhra Pradesh	Sri Venkateswara Institute of Medical Science (SVIMS), Tirupati
4.	Assam	Gauhati Medical College (GMC), Guwahati
5.	Bihar	All India Institute of Medical Sciences (AIIMS), Patna
6.	Chandigarh	Post Graduate Institute of Medical Education & Research (PGIMER)
7.	Delhi	National Centre for Diseae Control (NCDC), Delhi
8.	Gujarat	B.J. Medical College and Civil Hospital (BJMC), Ahmedabad
9.	Himachal Pradesh	Dr. Rajendra Prasad Govt. Medical College (DR RPGMC), Tanda
10.	Jammu and Kashmir	Sher-i-Kashmir Institute of Medical Sciences (SKIMS), Soura, Srinagar
11.	Jharkhand	Rajendra Institute of Medical Sciences (RIMS), Ranchi
12.	Jharkhand	Mahatma Gandhi Memorial Medical College (MGMMC), Jamshedpur
13.	Kerala	State Public Health Laboratory (SPHL), Trivandrum
14.	Karnataka	National Institute of Virology, Bangalore
15.	Karnataka	Hassan Institute of Medical Sciences (HIMS), Hassan
16.	Kerala	National Institute of Virology, Alaphuzha, Kerala Unit
17.	Madhya Pradesh	Gandhi Medical College, Bhopal
18.	Madhya Pradesh	National Institute of Research in Tribal Health (NIRTH), Jabalpur
19.	Maharashtra	ICMR-National Institute of Virology (NIV), Mumbai Unit
20.	Maharashtra	Kasturba Medical College (KMC), Mumbai
21.	Odisha	Regional Medical Research Centre (RMRC), Bhubaneswar
22.	Rajasthan	Sawai Man Singh (SMS) Medical College, Jaipur
23.	Tamil Nadu	Govt. Mohan Kumaramangalam Medical College (GMKMC), Salem
24.	Tamil Nadu	King Institute of Preventive Medicine & Research (KIPM), Chennai
25.	Telangana	Institute of Preventive Medicine (IPM), Hyderabad
26.	West Bengal	Institute of Serology (IoS), Kolkata
27.	Uttarakhand	Govt. Medical College (GMC), Haldwani
28.	Uttar Pradesh	Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGIMS), Lucknow

DP Labs

S. No.	State Name	Lab Name
1.	Andhra Pradesh	Guntur Medical College, Guntur
2.	Bihar	All India Institute of Medical Science, Patna
3.	Chandigarh	Post Graduate Institute of Medical Education and Research, Chandigarh
4.	Chhattisgarh	All India Institute of Medical Science, Raipur
5.	Gujarat	B.J. Medical College, Ahmedabad
6.	Jammu & Kashmir	Srinagar Medical College, Jammu & Kashmir
7.	Karnataka	Bangalore Medical College & Research institute, Bangalore
8.	Kerala	State Public Health and Clinical Laboratory, Trivandrum
9.	Kerala	Guwahati Medical College, Guwahati
10.	Madhya Pradesh	Choithram Hospital & Research Centre, Indore
11.	Maharashtra	Kasturba Medical College, Mumbai
12.	Odisha	Regional Medical Research Centre (RMRC), Bhubaneswar
13.	Pondicherry	The Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry
14.	Rajasthan	Swai Man Singh Medical College, Jaipur
15.	Rajasthan	All India Institute of Medical Science, Jodhpur
16.	Tamil Nadu	Christian Medical College, Vellore
17.	Tamil Nadu	State Public Health Laboratory, Chennai
18.	Telangana	Govt. Fever Hospital, Hyderabad
19.	Uttar Pradesh	King George's Medical University, Lucknow
20.	West Bengal	Calcutta School of Tropical Medicine, Kolkata

ANNEXURE IV

District Weekly Report (DWR) Format

Minutes of District Weekly Review (DWR) Meeting **(Surveillance & Routine Immunization)**			
State:		District:	
Date of DWR meeting:			
Review conducted for week no: Meeting chaired by: Dr. Anju Singla		Designation: DIO	
Sr. No.	Name	Designation	Signature
1			
2			
3			
4			
5 6			
7			
8 9			
10			
Follow up of decisions taken in last DWR meeting:			

Name of system	No. of weekly reports expected	No. of weekly reports received	Name of reporting sites from where weekly report not received
WHO-NPSP Case based surveillance			
IDSP			

Reporting by	Suspected Measles	AFP	Suspected Diphtheria	Suspected Pertussis
Through IDSP Through WHO-NPSP Case based Surveillance				
Final case count after matching the cases from two systems (remove duplicate records)				
*Final: (to be filled in D001 and district level P form)				

*NOTE: Match the cases reported through both systems and come at the final number of case/s; check that filled CIF available at DIO/SMO office for cases reported through both system

ANNEXURE V

Epidemiological Investigation Checklist WPV/VDPV/SL2

Epidemiological Investigation Checklist WPV/VDPV/SL2

(This checklist is to be used to guide data collection – any additional data relevant needs to be collected separately).

EPID Number **Date of onset of paralysis**

Has the area of residence of this case been identified as a high risk area under immunization program: Yes / No

DETAILS PERTAINING TO CASE & FAMILY

FIRST cross-check the details on the CIF & Epidemiological Investigation Format – note any discrepancies in a COPY of the ORIGINAL CIF and obtain the following additional details

Occupation

Grandfather's:

Father's :

Mother's:

Caste:

Economic status:

Literacy status of household members:

Travel History (Last six month before of date of onset/date of notification upto current date)

Take detailed travel (to/ from) history: to include dates/period of travel, origin and destination, purpose of travel (e.g. religious, occupation, festivals, social), mode of transport etc.

Travel By	Details
Child	
Family	
Relative	

Location where the child resided in the last 3 months – Use separate sheets or page overleaf if space and number is not enough

Description	Usual Location	Location 1
Dates **District** **Block** **Village/ Mohalla** **Local detailed address** **Contact Telephone Number** **Landmarks (at any location where child may have been infected with WPV/VDPV) including roads, highways – detailed description with map overleaf** **Nearest health facility** **Nearest public transport (railway station/ bus station etc)** **Address of close relatives**		

Brief environmental details

	Status
Drinking Water	
Type of Toilet	
Drainage	

Immunisation

Details	Description
Vaccination history for the case (all vaccines)	
Doses received during SIAs of past one year by each child <5 yrs in this household (specify each child)	
Child's household markings for last 3 rounds (Explain reason for "X")	
OPV and fIPV status of children below 5 years in the household	
RI session details	

Important Note: Use the ERC 001 form to assist in doing a clinical examination of the child (Even if 60 days are not completed)

DETAILS PERTAINING TO COMMUNITY (Block)

Demographic data

Total population of village/ward and block:

Population of children <5 yrs: Village / ward and block

Population density of village/ward (dense/normal/sparse)

Literacy

Religious break-up

Caste break-up

Major occupation(s)

Environmental conditions Drinking water, Toilets, Drainage in the village / ward

Travel/Movement of community Fairs, Festivals, Seasonal migration (e.g. related to occupation)

Date of Investigation:
Place

Signature & Name of Investigator

Date: **Community Survey Form** Name of Monitor:

District **Block** **Village/ Ward** **Locality**

House no		1	2	3	4	5	6	7	8	9	10
Total no of children 0-5 years											
No. of children <5 years found unimmunised in the last SIA round, held in _____/_____											
No. of children < 5 years who missed at least 1 dose of OPV during SIAs in the last 2 rounds											
No. of children < 5 years who did not receive any OPV during SIAs in the last 2 rounds											
No. of children < 5 years who received ALL doses of OPV during SIAs in the last 2 rounds											
Travel out by Family in the last 6 months (Write place name)	To State										
	To District										
	To Block										
	< 5 Child travel	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Visits to family in the last 6 months (Write place name)	From State										
	From District										
	From Block										
	< 5 Child travel	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Religion											
Caste											
Occupation											
Practice of open defecation in family		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
H/o measles in last 3 months											
H/o diphtheria in last 3 months											
Any AFP case in last 6 months in house or neighbourhood (write address)											
In/out migration from/to other country											

Assessment of Health Facilities for Sensitivity on AFP Surveillance

Assessment of health facilities for sensitivity on AFP surveillance									
State				District				Block	
Sl. No.	Name of the health facility / Doctor	Facility type (Allopathic / ISM / Quack)	Is it part of our reporting site (Y/N)	Mobile number	Address	Average daily number of OPD for children <15 year	No. of AFP cases seen in last 6 months	No. of AFP cases reported in last 6 months	Missed AFP case details

Contact Sample Format

Linelist of Stool Specimens Collected from Contacts / Community under Polio Surveillance

EPID number of Index Case:_____

Block:			District:			State:			
Identification Number	Name	Sex	Age	Mobile no	Village/ Mohalla	Total OPV doses	Total IPV doses	Date last dose of OPV	Date stool sample collection

Name of the laboratory:	Date sample sent to the lab: ____/____/_____
Name of person sending the specimen:	Designation:
Email ID:	Mobile/WhatsApp Number:
Address:	

Receiving at Laboratory:

Date sample received in the lab:_____/_____/_____

Condition of the sample/s: Good / Poor

If poor, specify:

Signature:

Lab Stamp:

Immunization – House to House Monitoring Format

Routine Immunization House to House Monitoring Format - 2023

Monitor to follow "Standard Operating Procedure" (SOP) and refer "Ready Reckoner" during monitoring. Encircle appropriate options. For (*) marked questions multiple responses are allowed

State/UT: …… District: …… Date: __/__/__ Type of monitoring: RI / SIW / Others (specify) …… Monitoring time: __: __ to __: __

Block/ Urban area: …… CHC/PHC/UPHC/Others:…… Planning unit: …… Subcenter/ ANM area:…… Session site/s for this area:……

Village/ Ward/ Mohalla:…… Setting: Urban / Rural; HRA: Yes/ No; $If Yes, mention code: $ 1/ 2/ 3 / 4/ 5 / 6A / 6B / 6C / 6D / 6E / 6F; Is there an ongoing measles outbreak in this area? Yes / No

Name of Monitor(s): 1) ……; 2) …… Organization: Govt/ WHO / UNICEF/ JSI / CHAI / Others (specify): ……; …… Designation(s): ……; ……

 # Codes for HRA: 1: Slum with migration 2: Nomads 3: Brick kiln 4: Construction site 5: Other migratory sites 6A: Settled Slum 6B: Hard to Reach areas 6C:Vacant Subcenter 6D: VPD outbreak areas 6E: Vaccine hesitancy 6F: Others

Monitor to visit 10 households (HH)			7 HH for 7 children 0-23 months (up to 2 years)							3 HH for 3 children 24-59 months (2 to 5 years)		
Details of child and vaccination status in monitored Households			HH-1	HH- 2	HH-3	HH-4	HH-5	HH-6	HH-7	HH-1	HH-2	HH-3
Details of sleeted child	1a	Name of the selected child										
	1b	Name of the Father/Mother of the child										
	1c	Person providing information [Mother = M; Father = F, Grandparents = G , Others = O]	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O	M / F / G / O
	1d	Religion (**H**=Hindu, **M**=Muslim, **C**= Christian, **O**=Others)	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O	H / M / C / O
	1e	Gender of the child: **M**=Male, **F**=Female, O= Other	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O
	1f	Place of delivery: **G** = Govt Hospital, **P** = Private Hospital, **H** = Home	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H	G / P / H
	1g	Date of birth (dd/mm/yy). [if not known, write NA]										
	1h	Age in completed months										
	$1i	Source of information on vaccination status MCP/RI **C**ard = **C**, Recall = **R** ; e-Vaccination certificate = eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC	C / R / eVC
Write dates (dd/mm/yy) for each vaccine received if MCP /RI / eVC is available. In case of recall write Yes / No. Mention "NA" for vaccine if child is not due for vaccine in view of age or the vaccine has not been/was not introduced in the district or the child was not eligible												
At birth	2a	**Hep-B birth dose** *Administered within 24 hours of birth*										
	2b	**bOPV-0 dose** *as early as possible, within 15 days of birth*										
	2c	**BCG** *at birth, within 1 year of age*										
At 6 weeks	3a	**bOPV-1** *at 6 weeks, can be given up to 5 years of age*										
	3b	**RVV-1** *at 6 weeks, not to start after 1 year of age*										
	3c	**fIPV-1** *at 6 weeks, not to start after 1 year of age*										
	3d	**PCV 1** *at 6 weeks, not to start after 1 year of age*										
	3e	**Pentavalent-1** *at 6 weeks (not to start after 1 year of age)*										
	3f	**DPT-1** *(can be given if Penta-1 not started within 1 year of age)*										
At 10 weeks	4a	**bOPV-2** *at 10 weeks*										
	4b	**RVV-2** *at 10 weeks*										
	4c	**Pentavalent-2** *at 10 weeks*										
	4d	**DPT-2** *(If DPT is initiated, else NA)*										
At 14 weeks	5a	**bOPV-3** *at 14 weeks*										
	5b	**RVV-3** *at 14 weeks*										
	5c	**fIPV-2** *at 14 weeks*										
	5d	**PCV2** *at 14 weeks*										
	5e	**Pentavalent-3** *at 14 weeks*										
	5f	**DPT-3** *(If DPT is initiated, else NA)*										

Monitor to visit 10 HH			7 HH for 7 children 0-23 months (up to 2 years)							3 HH for 3 children 24-59 months (2 to 5 years)		
Details of child and vaccination status in monitored Households			HH-1	HH- 2	HH-3	HH-4	HH-5	HH-6	HH-7	HH-1	HH-2	HH-3
At 9 -11 months	6a	**Vitamin A syrup** *at 9-11 months, then 6 monthly up to 5 years*										
	6b	**fIPV-3** *at 9-11 months*										
	6c	**MR-1** *at 9-11 months can be given up to 5 years of age*										
	6d	**PCV Booster** *at 9-11 months*										
	6e	**JE-1 (where applicable)** *at 9-11 months up to 2 years of age*										
At 16-23 and 24-59 months	7a	**bOPV Booster** *at 16-23 months. Can be given up to 5 years*										
	7b	**Vitamin A syrup:** *Total doses received for the age*										
	7c	**MR-2** *at 16-23 months, if MR1 delayed, MR2 after 1month of MR1 & not before 16 months*										
	7d	**JE-2;** *at 16-23 months. If JE1 delayed, JE2 after 1 month of JE1 & not before 16 months. In delayed case JE2 up to 3 years*										
	7e	**DPT Booster-1** *at 16-23 months, can be given up to 7 years*										
Vaccination Status	8a	Has the child received all age-appropriate vaccine doses? *(Ref. ready reckoner).* [Ignore Hep-B birth dose and OPV-0 dose]	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
	*8b	If child has missed some / all due dose(s), ascertain reason(s) as told by caregiver [max. of 2 reasons by codes from table below)										

Reasons for not getting due dose/s: **1)** Not aware of need for immunization **2)** No one contacted **3)** Concern for loss of work or wages **4)** Session inconvenient **5)** Unfriendly behaviour of HW **6)** Session found closed **7)** Vaccine not available **8)** Child was travelling or away from home **9)** Child was/is sick **10)** Fear of multiple injections **11)** Fear of AEFI **12)** Adverse media reports; **13)** Family is resistant **99)** Others: .....

MR1/MR2 status in 24-59 months children										
	9a	Is there any child 2 to 5 yrs in this household? If yes, fill the details for the youngest child of 2-5 yrs, in 9b, 9c and 9d, else skip to Q10	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	If any child is found to have missed any vaccine including MR1 / MR2 – inform MOIC and key staff to ensure such children are vaccinated.
	9b	Whether the child has received MR 1	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
	9c	Whether the child has received MR 2	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	
	9d	If not received MR 1/ MR 2, name of the child								

Behavior & Social Driver												
	10a	How important do you think vaccines are for your child's health? Would you say: 1. Not at all important 2. A little important 3. Moderately important 4. Very important?	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4
	10b	Do you think most of your close family and friends want you to get your child vaccinated?	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
	10c	Do you want your child to get vaccines under UIP? **1** None **2** Some **3.** All	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3
	10d	Do you know where to go to get your child vaccinated?	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
	10e	How easy is it to pay for vaccination? (When you think about the cost, please consider any payments to the clinic, the cost of getting there, plus the cost of taking time away from work. Would you say) 1. Not at all easy 2. A little easy 3. Moderately easy 4. Very easy	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4	1 / 2 / 3 / 4

Notes:

Ready reckoner to ascertain vaccination status of the selected child during RI / MI monitoring

Age (Completed months)	Ideally a child should have received age specific vaccines as per National Immunization Schedule • Monitor has to assess **RI vaccination status** of the selected child considering purely the age eligibility ignoring time interval between doses and reasons for delayed or no vaccination. • Monitor has to assess **vaccination status** of the selected child during Mission Indradhanush monitoring considering child's eligibility for vaccine based on previous vaccination / time interval between doses for the age.										
	BCG	**OPV**	**Hep-B**	***Rotavirus (RVV)**	****IPV**	*****PCV**	**DPT + Hepatitis-B / ******Pentavalent**	**Measles / MR**	*******JE**	**DPT Booster-1**	**OPV Booster**
0	BCG	OPV-0 (up to 15 days)	Birth dose (Within 24 hours)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
1	BCG	OPV-0 (up to 15 days)	Birth dose (Within 24 hours)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
2	BCG	OPV-0,1	Birth dose (Within 24 hours)	RVV-1	**NA- In states with IM schedule fIPV-1 in select states/UT**	PCV -1	(DPT-1+Hepatitis-B-1) / Pentavalent-1	**NA**	**NA**	**NA**	**NA**
3	BCG	OPV-0,1,2	Birth dose (Within 24 hours)	RVV -1,2	**NA- In states with IM schedule IPV-1 Intradermal dose in select states/UT**	PCV - 1	(DPT-1,2 + Hepatitis-B-1,2) / Pentavalent-1,2	**NA**	**NA**	**NA**	**NA**
4 to 8	BCG	OPV-0,1,2,3	Birth dose (Within 24 hours)	RVV -1,2,3	**NA- In states with IM schedule fIPV-1,2 in select states/UT**	PVV -1, 2	(DPT-1,2,3 + Hepatitis-B-1,2,3) / Pentavalent-1,2,3	**NA**	**NA**	**NA**	**NA**
9 to 15	BCG	OPV-0,1,2,3	Birth dose (Within 24 hours)	RVV -1,2,3	**IM dose in select states/UT fIPV-1,2 in select states/UT**	PCV-1, 2, 3	(DPT-1,2,3 + Hepatitis-B-1,2,3) / Pentavalent-1,2,3	Measles/MR -1	JE - 1	**NA**	**NA**
16 - 23 OR 16 - 35	BCG	OPV-0,1,2,3	Birth dose (Within 24 hours)	RVV -1,2,3	**IM dose in select states/UT fIPV-1,2 in select states/UT**	PCV-1, 2, 3	(DPT-1,2,3 + Hepatitis-B-1,2,3) / Pentavalent-1,2,3	Measles/MR- 1,2	JE - 1, 2	DPT Booster -1	OPV Booster

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

** **IPV**: IPV should not be administered in a child over one year of age.

- IPV given IM along with OPV-3 at 14 weeks / later but within 1 year of age. Now few states have switched from IM single dose schedule to 2 fractional IPV doses (fIPV doses) in 2017. Assessment of the IPV/fIPV vaccination status of the child being monitored has to be based on eligibility of the child for IPV Or fIPV.

*** PCV: Introduction of PCV is planned in 2017 in phase manner. It may be introduced during Mission Indradhanush phase –IV in states of Bihar, Himachal Pradesh and Uttar Pradesh.

- PCV given IM in right thigh along with OPV-1 at 6 weeks / later but within 1 year of age (PCV1), PCV2 at 14 weeks/later along with OPV3 and PCV3 (booster) dose at 9 months.

******Pentavalent** vaccine has replaced the primary doses of DPT & Hepatitis-B at 6, 10 and 14 weeks of age while DPT booster dose would be administered at 16-24 months of age.

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

Assess vaccination status of the selected child during Mission Indradhanush as per age and time interval between vaccines as below:

- There has to be at least 4 weeks interval between subsequent doses of pentavalent vaccine after 1st dose.
- There has to be at least 4 weeks interval between two different live vaccines if not being given simultaneously (BCG/Measles/JE vaccines)
- There has to be an interval of at least 1 month between 2 doses of Measles, and 3 months between two doses of JE vaccines.
- There has to be at least six months gap between 3rd dose of DPT/Pentavalent and 1st DPT booster.

ANNEXURE VI

Reporting Forms

VPD – H001

Form VPD - H001		
ASSESSMENT OF HOSPITAL SURVEILLANCE FOR ENROLLMENT AS A REPORTING UNIT (RU) IN VPD SURVEILLANCE NETWORK		
1	Date of Visit: _____	
2	Name and address of Hospital: _____ Block/Planning Unit_____ District: _____ State: _____	
3	Is there a registry of all patients seen in the out-patient department?	Yes / No
	If yes, does the registry include: suspected diagnosis / chief complaints / address of current residence?	
	If yes, does the registrar/staff know to report cases of VPD?	Yes / No
	If there is a registry, review the past month and enter number of VPDs found here: AFP_____; FR _____; Diphtheria_____; Pertussis_____; Neonatal Tetanus_____	
4	Is there a registry of all patients admitted?	Yes / No
	If yes, does the registry include: suspected diagnosis / chief complaints / address of current residence?	
	If yes, does the registrar/staff know to report cases of VPD?	Yes / No
	If there is a registry, review the past month and enter no. of VPD found below: AFP .....; FR .....; Diphtheria .....; Pertussis .....; Neonatal Tetanus	
5	Is there a registry of all patients discharged?	Yes / No
	If yes, does the registry include: discharge diagnosis / address of current residence?	
	If yes, does the registrar / staff know to report cases of VPD?	Yes / No
	If there is a registry, review the past month and enter no. of VPD cases found below: AFP .....; FR .....; Diphtheria .....; Pertussis .....; Neonatal Tetanus	
6	Are medical records filed by date of admission, date of discharge, alphabetical, or other method?	
	If by date of discharge, enter the number VPD cases found in the last month here: AFP .....; FR .....; Diphtheria .....; Pertussis .....; Neonatal Tetanus	
7	Are cases seen in the OPD reported to the district health office?	Yes / No
8	Are admitted cases reported to the district health office?	Yes / No
9	Are all VPD cases reported before diagnosis is confirmed?	Yes / No
10	Is there one person responsible for reporting cases to the district health office? Yes / No If yes, who? Name: _____ Telephone No. : _____	
11	To whom are reports sent? _____	
12	How are reports communicated? telephone/ fax / meeting / SMS /email / WhatsApp	
13	Are "NIL" reports made?	Yes / No/NA
14	Number of VPD cases reported last year: AFP .....; FR .....; Diphtheria .....; Pertussis .....; Neonatal Tetanus	
15	Who is responsible for case investigation and CIF filling? Name: _____ Telephone No.:_____	
16	Who is responsible for sample collection? Name:_____ Telephone No.:_____	
17	Sample collection kit available: AFP – Yes / No; FR – Yes / No; Diphtheria & Pertussis – Yes / No	
18	Meeting with Hospital Director Yes / No Name: _____ Telephone No. :_____	
19	19. Meeting with Chief of Paediatrics? Yes / No Name: _____ Telephone No. :_____	
20	Meeting with Chief of Neurology? Yes / No Name: _____ Telephone No. :_____	
21	Scheduled presentation of medical staff: Date:_____ Time: _____	
*Encircle the responses; AFP=Acute Flaccid Paralysis; FR=Fever Maculopapular Rash		

VPD-H002

Form VPD-H002

AFP, iVDPV AND VPD SURVEILLANCE - WEEKLY HOSPITAL REPORT

After review of all wards and registry books, please send this report to the following person every Monday.

Name: _____ **Designation**_____

Address: _____

Tel./Fax: _____ **Mobile:** _____ **E-Mail:** _____

Name of Reporting Hospital:_____ **Year:** _____

Week No. _____ **Period included in the report:** **From:** _____ **To:** _____

Number of AFP/ suspected VPD cases Identified: If no cases were identified, write Zero (0)	AFP	FR	Diphtheria	Pertussis	Neonatal Tetanus

 # AEFI: Serious _____ Severe _____ **Typhoid Fever:**_____ **# PID case** _____

Write the case details of AFP/PID cases identified and reported this week

Patient's name and Father's name	Age in months	Sex	Contact Number	Village name and landmark	Block name	District name	Outcome: Died? (Y/N/U)#	AFP / PID Case

Information on suspected cases of VPDs (Fever maculopapular rash, Diphtheria, Pertussis and Neonatal Tetanus, Typhoid fever):

Patient's name and Father's name	Age in months	Sex	Contact Number	Village name and landmark	Block name	District name	Outcome: Died? (Y/N/U)#	Type of VPD (FR / D / P / T / TYF)##

 # Y=Yes, N=No, U=unknown

FR=Fever Maculopapular Rash, D=Diphtheria, P=Pertussis, T=Neonatal Tetanus, PID=Primary Immunodeficiency, TYF - Typhoid fever

Name of person filling this report: _____ **Date report sent to District:** _____

Approval of Medical Officer/Director:_____

Reporting site should report weekly even if no cases of AFP, PID, FR, DPT or Typhoid fever were identified

VPD-H003

Form VPD-H003

REPORTING UNIT/HOSPITAL ACTIVE SEARCH FORM

Year:___________ Half: 1st / 2nd

RU/Hospital:________________________ District: __________________ State: _______________________ Nodal Officer: ___________________________

Every Monday morning, Nodal officer should ask all relevant medical staff regarding AFP/PID and VPD cases that were seen during previous week. He/ She should also visit the wards and emergency/ casualty areas. Please mark "X" when staff could not be contacted. Write the number of cases seen by the doctor. If no case seen, then write "0".

		Week number *(enter 1-26 for 1st half year, 27-53 for 2nd half year)*																										
Today's date ***(write date when consulted)*** ➔																												
Dr. ______	**AFP**																											
	FR																											
	Diphtheria																											
	Pertussis																											
	Neonatal Tetanus																											
Dr. ______	**AFP**																											
	FR																											
	Diphtheria																											
	Pertussis																											
	Neonatal Tetanus																											
Dr. ______	**AFP**																											
	FR																											
	Diphtheria																											
	Pertussis																											
	Neonatal Tetanus																											
Dr. ______	**AFP**																											
	FR																											
	Diphtheria																											
	Pertussis																											
	Neonatal Tetanus																											
Dr. ______	**AFP**																											
	FR																											
	Diphtheria																											
	Pertussis																											
	Neonatal Tetanus																											
Dr. ______	**Typhoid fever**																											
Dr. ______	**PID**																											
Dr. ______	**PID**																											

* AFP=Acute Flaccid Paralysis; FR=Fever Maculopapular Rash; PID = Primary Immunodeficiency

VPD-H003A

FORM VPD-H003-A **HOSPITAL ACTIVE SURVEILLANCE FORM** **YEAR:_____** **HALF: 1st/2nd**

HOSPITAL:_____ **DISTRICT:_____** **STATE:_____** **Nodal Officer: _____**

Every Monday morning, visit the different departments and wards searching for AFP and VPD cases
Write the number of AFP/ VPD cases seen in that department in the previous week. If no case seen, then write "0".

			Week number *(enter 1-26 for 1st half year, 27-53 for 2nd half year)*																										
	Today's date *(write date when consulted)* ➔																												
1	**Pediatric Department**	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
		Typhoid fever																												
2	**General Medicine department**	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
		Typhoid fever																												
3	**Neurology Department**	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
4	**Casualty/Emergency department**	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
5	**Intensive care unit**	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
6	**Orthopedics Department**	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
7	**Immuno-hematology Department**	**PID**																												
	Signed initials of Nodal officer																												
	Total number of cases	**AFP**																												
		FR																												
		Diphtheria																												
		Pertussis																												
		Neonatal Tetanus																												
		Typhoid Fever																												

* AFP=Acute Flaccid Paralysis; FR=Fever Maculopapular Rash

VPD-D001

Form VPD-D001

AFP, iVDPV AND VPD SURVEILLANCE SYSTEM - WEEKLY DISTRICT REPORT

Please send this report to the following person every Tuesday:

Name:_____ Address:_____

Tel./Fax:_____ Mobile:_____ E-Mail: _____

Name of reporting district:_____ Year:

Week No: Period included in the report: From: To:

Number of units expected to report: _____ Number of units reporting on time: _____

Number of AFP/ suspected VPD cases Identified:
If no cases were identified, write Zero (0)

AFP	FR	DTH	PTS	NNT	PID	TYF

AEFI

Serious	
Severe	

Names of Reporting Units not reported on time this week:

Write EPID numbers of AFP and PID cases identified and reported this week:

Write EPID numbers of suspected VPD cases identified and reported this week:

Fever Maculopapular Rash (FR)	Diphtheria (DTH)	Pertussis (PTS)	Neonatal Tetanus (NNT)		Typhoid Fever

Fill up information on all FR cases below

	Block name	Number of Cases	Number of Deaths	Flagged for preliminary investigation		
				Y / N	If No, give reason	If Yes, allot Outbreak ID (#)
Blocks within the reporting district						
	District total:					

Blocks outside of reporting district

District name	Block name	Number of Cases	Number of Deaths	Cross-notified to the concerned District?		
				Y/N	If No, give reason	If Yes, date cross-notified to

Note: The number of suspected measles deaths should be counted as measles cases also.
Cases from previous week should also be considered while flagging for preliminary investigation. Similarly deaths in cases reported from previous weeks should be considered.

The reasons for not flagging for preliminary investigation are:

1 - there are less than 5 suspected measles cases and no deaths in a block in continuous 4 weeks

4 - suspected measles cases or death due to measles reported in this week belongs to an already investigated outbreak, In this case mention the outbreak Id. already allotted (#)

FR= Fever maculopapular rash

Name of person filling out report: _____ Date report sent to State: _____

Approval of District Immunization Officer_____

All districts should report weekly even if no cases of AFP, PID, FR, DPT or Typhoid Fever were identified

VPD-D002

SUMMARY TIMELINESS AND COMPLETENESS OF WEEKLY REPORTS

VPD-D002

District:__________________ **District code:**_______ **State:**____________________ **Surveillance officer:**_________________

Year:___________ *Place an "X" in the:* **T** *column if report received on* **time** *(by Tuesday noon)*

L *column if report received* **late** *(after Tuesday noon, but before the next Monday)*

Quarter:______ **N** *column if report is* **not received** *by the next Monday*

	Week number *(enter 1-13 for 1st quarter, 14-26 for 2nd quarter, 27-39 for 3rd quarter, 40-53 for 4th quarter)*																																							
Name of reporting unit	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	T	L	N	RU% reported on time
a) Total expected (T+L+N)																																								
b) Total received (T+L)																																								
c) % received (100 x b/a)																																								
d) Total on time (T)																																								
e) Weekly% on time (100xd/a)																																								

Page ____ of ____

VPD-D003

ACTIVE / TELEPHONIC CASE SEARCHES AT REPORTING SITES

Form VPD-D003

Page of

Year: **State:**

District:____________________ **District code**________ **Reporting officer:**____________________

Indicate the date of each active / telephonic search and the number of ***unreported cases*** *found.*

Details of Reporting Site	Month / Missed cases	Jan		Feb		Mar		Apr		May		Jun		Total	
		Visit	Tel	Visit	Tel	Visit	Tel	Visit	Tel	Visit	Tel	Visit	Tel	Visit	Tel
Name:	Dates														
	AFP														
	FR														
PH:	Diphtheria														
Code:	Pertussis														
VHP / HP / LP	NNT														
Name:	Dates														
	AFP														
	FR														
PH:	Diphtheria														
Code:	Pertussis														
VHP / HP / LP	NNT														
Name:	Dates														
	AFP														
	FR														
PH:	Diphtheria														
Code:	Pertussis														
VHP / HP / LP	NNT														
Name:	Dates														
	AFP														
	FR														
PH:	Diphtheria														
Code:	Pertussis														
VHP / HP / LP	NNT														
Name:	Dates														
	AFP														
	FR														
PH:	Diphtheria														
Code:	Pertussis														
VHP / HP / LP	NNT														
Name:	Dates														
	AFP														
	FR														
PH:	Diphtheria														
Code:	Pertussis														
VHP / HP / LP	NNT														
Name:	Dates														
PH:	PID														
Code:	TYF														
VHP / HP / LP															
Total number of searches															
Total number of unreported cases found	**AFP**														
	FR														
	Diphtheria														
	Pertussis														
	NNT														
	PID														

AFP: Acute Flaccid Paralysis; FR: Fever Maculopapular rash; NNT: Neonatal Tetanus; PID: Primary Immunodeficiency; TYF: Typhoid Fever

* Prioritization of reporting sites will be on the basis of AFP-MR surveillance system

VPD-S001

Form VPD-S001

ACUTE FLACCID PARALYSIS AND VPD SURVEILLANCE SYSTEM - WEEKLY STATE REPORT

Please send this report to the following person every Wednesday:

Name:_____ Address:_____

Tel./Fax:_____ Mobile:_____ E-Mail:_____

Name of reporting state:_____ Year: _____

Names of Reporting Units not reported on time this week:

Week No: _____ Period included in the report: From: _____ To: _____

Number of units expected to report: _____ Number of units reporting on time: _____

Number of AFP/ suspected VPD cases Identifie	AFP	FR	DTH	PTS	NNT	PID	TYF	AEFI	Serious	
If no cases were identified, write Zero (0)									Severe	

Names of Reporting Units not reported on time this week:

Write EPID numbers of AFP / PID cases identified and reported this week:

Write EPID numbers of suspected VPD cases identified and reported this week:

Fever maculopapular rash (FR)	Diphtheria (DTH)	Pertussis (PTS)	Neonatal Tetanus (NNT)	Typhoid Fever

Fill up information on all FR cases below

	District name	Block name	Number of Cases	Number of Deaths	Flagged for preliminary investigation		
					Y / N	If No, give reason	If Yes, mention Outbreak ID (#)
Blocks within the reporting state							
	State total:						

Districts outside of reporting state:

State name	District name	Block name	Number of Cases	Number of Deaths	Cross-notified to the concerned State?		
					Y/N	If No, give reason	If Yes, date cross-notified to the concerned State

Note: The number of measles deaths should be counted as suspected measles cases also.
Cases from previous week should also be considered while flagging for preliminary investigation. Similarly deaths in cases reported from previous weeks should be considered.
The reasons for not flagging for preliminary investigation are:

1 - there are less than 5 suspected measles cases and no deaths in a block in continuous 4 weeks
4 - suspected measles cases or death due to measles reported in this week belongs to an already investigated outbreak, In this case mention the outbreak Id. already allotted (#)
FR= Fever Maculopapular Rash

Name of person filling out report: _____ Date report sent to GoI: _____
Approval of State Immunization Officer_____

All states should report weekly even if no cases of AFP, PID, FR, DPT or Typhoid fever were identified

VPD-S002

Form AFP-S002

WEEKLY SUMMARY OF TIMELINESS AND COMPLETENESS OF DISTRICT REPORTS

Page ____ of _____

State:__________________ Quarter:____ Year:________ Reporting officer:__________________

For each District
- *# expected:* *write the total number of reporting units* **expected** *to report in each district each week*
- *# received:* *write the number of reporting units from which a report was received* ***either late or on time*** *(before noon Tuesday) for each week*
- *# on time:* *write the number of reporting units from which a report was received* ***on time*** *(before noon Tuesday) for each week*

District name & code	Reporting units	Week number *(enter 1-13 for 1st quarter, 14-26 for 2nd quarter, 27-39 for 3rd quarter, 40-53 for 4th quarter)*													Totals	% received (100 x r/e)	% on time (100 x t/e)
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
	# expected														e		
	# received														r		
	# on time														t		
a) Total expected																	
b) Total received																	
c) % received (100 x b/a)																	
d) Total on time																	
e) % on time (100 x d/a)																	

AFP - CIF

Acute Flaccid Paralysis
CASE INVESTIGATION FORM

EPID Number:
IND - ____ -_____ - _____ - _____
(matches Lab Request Form)

1. Notification / Investigation Information:

Date Case Notified: **15/09/2023** Notified by: **DR SURESH KUMAR** Title: **INFORMER**

Date Case Investigated: _____ / _____ / _____ Investigated by:_____ Title: DIO/Medical Officer/ Nodal Officer/ SMO/ Other

Date Case verified by DIO/SMO: _____ / _____ / _____ Name of DIO/SMO: _____

Notifying Health Facility:**Type** : RU/ Informer/ Other **Category**: VHP/ HP/ LP/ Other **Setup**: Govt. Allopathic/ Pvt Allopathic/ ISM Pract./ Quack/Others

2. Case Identification: Patient's Name: _____ other given names: _____

Sex: _____ Date of birth: _____/ _____ / _____ Age (at onset): years_____ months_____

Father's Name:_____ Mother's Name:_____

Father's Occupation:_____ Grand father's Name:_____

Address: _____ Religion: Muslim / Hindu / Other Caste: _____

Landmark: _____ Village / Mohalla: _____ HRA: Y / N

Panchayat/Ward No: _____ **Pin Code:** _____ **ID No:( )**_____

Block /Urban area: _____ District: _____ Setting: Urban / Rural

State: _____ Tel. _____ **Alternate tel.** _____

Child belongs to migratory family/Community : Yes/ No/ Unknown If yes, specify: Slum with migration/ Nomad/ Brick Kiln/ Construction site/ Others (specify): _____

3. Hospitalization: Yes / No Date of Hospitalization:____/____/____

Name of Hospital:_____ Diagnosis as per hospital records, if any: _____

4. Immunization History: a. OPV doses received through routine EPI (before onset): _____

b. OPV doses received through SIAs (before onset): _____ Total OPV doses (a+b): _____

Date of last dose of OPV (before onset): _____/ _____/_____ (to be filled in linelist)

Date of last dose of OPV (before stool collection): _____/ _____/_____ (to be filled in LRF)

Number of f-IPV doses received (before onset): _____ Number of IM-IPV doses received (before onset): _____

Date of last dose of f-IPV (before onset): _____/ _____/_____ Date of last dose of IM-IPV (before onset): _____/ _____/_____

5. Clinical Symptoms: Date of Paralysis Onset:_____/_____/_____

Number of days from onset to maximum paralysis:_____

Acute paralysis: Yes / No / Unknown Flaccid paralysis (anytime during course of illness)Yes/ No/Unknown

Any Injections during 30 days before paralysis onset: Yes / No / Unknown If Yes, side and site of injection _____

Fever on day of paralysis onset: Yes / No / Unknown

Ascending paralysis: Yes / No / Unknown Descending paralysis: Yes / No / Unknown

6. Clinical history: (write evolution and progression of illness)

Respiratory involvement: Yes/ No
Bulbar involvement: Yes/ No
Bladder/bowel: Yes/ No
Joint pain/Swelling: Yes/ No
Gait:

7. Travel history: Travel of child within 35 days prior to onset of paralysis (indicate dates and place of travel with arrows on dateline)

Write dates of travel: **Day of onset**

35 34 33 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 16 15 14 13 12 11 **10** **9** **8** **7** 6 5 4 3 2 1 0

Write here places visited corresponding to the travel dates

Requires cross notification? Yes / No

If yes, date of cross notification:

District of residence: _____

Block/ Urban area of residence: _____

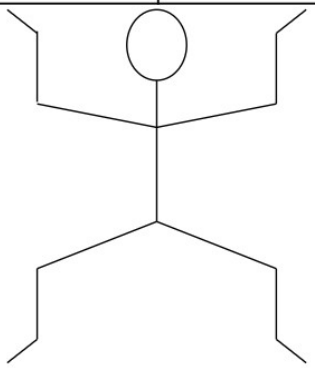
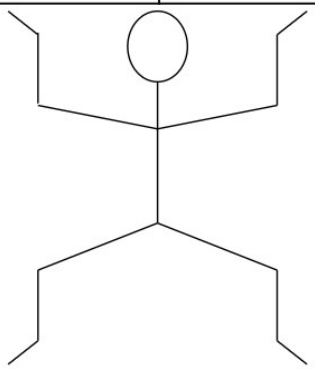
8. History of contacts with healthcare providers after the date of paralysis onset (including the notifying health facility):

Name, mobile number and address of Hospital/ doctor/ quack:	1	2	3	4
Dates case visited:				
Already RU/informer?	Yes/No	Yes/No	Yes/No	Yes/No
Did they report this case?	Yes/No	Yes/No	Yes/No	Yes/No
Action taken by SMO / Date of visit by SMO				

CIF contains two pages, both pages must be filled for all AFP cases

Identification Number Code: 1 - Aadhaar card, 2 - Voter Card, 3. PAN, 4. Passport, 5. Driving licence number, 6. National Health ID, 7. State Health ID, 8. Other

CIF (Page 2) **EPID No.:** IND - ____ -_____ - _____ - _____

9. Clinical examination:	**Initial case investigation; Date:** _____		**60-day follow-up; Date:** _____	
	Examined by : _____		**Examined by :** _____	
Tone: (normal/↑/↓)	**UL**: Right:	**LL**: Right:	**UL**: Right:	**LL**: Right:
	Left:	Left:	Left:	Left:
Power: (Grade 0 to 5) *0 - No Contraction* *1 – Flicker of contraction* *2 – Active movement with gravity eliminated* *3 – Active Movement against gravity but no resistance* *4 - Active Movement against resistance* *5 – Normal*				
Reflexes:	**N/ ↑/ ↓/ absent/ uncooperative child**	**N/ ↑/ ↓/ absent/ uncooperative child**	**N/ ↑/ ↓/ absent/ uncooperative child**	**N/ ↑/ ↓/ absent/ uncooperative child**
Biceps:	Right	Left	Right	Left
Triceps:	Right	Left	Right	Left
Supinator:	Right	Left	Right	Left
Knee jerk:	Right	Left	Right	Left
Ankle jerk:	Right	Left	Right	Left
Plantar:	Right: *flexor / extensor/ Uncooperative child*	Left *flexor / extensor/ Uncooperative child*	Right *flexor / extensor/ Uncooperative child*	Left: *flexor / extensor/ Uncooperative child*
Circumference: Mid-	Right	Left	Right	Left
Fore-arm:	Right	Left	Right	Left
Mid-thigh	Right	Left	Right	Left
Mid-calf:	Right	Left	Right	Left
Cranial nerves affected	Right	Left	Right	Left

Sensation loss: Yes / No / Unknown Asymmetrical paralysis: Yes / No / Unknown Hot AFP case: Yes / No

Site(s) of Paralysis: right arm / left arm / right leg / left leg / neck / bulbar / respiratory muscle / trunk / facial/ other_____

10. Provisional diagnosis:

Guillain-Barre Syndrome / Transverse Myelitis / Traumatic Neuritis / Transient Paralysis / Facial Palsy / other / Unknown If other, specify: _____

AFP case: Yes / No If No, reason for rejection: Injury / spastic paralysis / onset >6 months / congenital defect / other (specify)_____

If yes, case selection based on: Flaccid paralysis at the time of investigation / History of flaccid paralysis but no paralysis at the time of investigation / Borderline or ambiguous case

11. Contact stool: Was this case eligible for contact stool collection: Yes / No If yes, date collected: _____/_____/_____

12. Stool Specimen Collection:

	Date Collected	Time Collected	Date Sent	Date of Result	Condition						
Stool 1	___/___/___	___:___	___/___/___	___/___/___	Good / P	P1	P2	P3	Wild/Vaccine	NPEV	Negative
Stool 2	___/___/___	___:___	___/___/___	___/___/___	Good / P	P1	P2	P3	Wild/Vaccine	NPEV	Negative

If Stool Not Collected in 14 days why? Late Notification/ Late investigation/ Delay in stool collection/ Constipation/ Death/ Lost/ Other

13. Name of Govt Health Facility Responsible for Active Case Search and Outbreak Response: _____

_____ Active case search in community done: Yes / No

ORI done: Yes / No If yes, date begun: ___/___/___ Additional AFP case found: Yes / No Number:_____

If no, why?_____ Date active case search conducted: ___/___/___

14. 60 Day Follow-up Examination: Not required / Yes / Death / Lost if died, date of death: ____/____/____

Date of follow-up: ____/____/____ Residual weakness present: Yes/No cause of death: _____

Site of weakness: right arm / left arm / right leg / left leg / neck / bulbar / respiratory muscle / trunk / facial/other _____

15. Final Classification: Confirmed Polio / Compatible / Discarded

If compatible, why? _____

If discarded, what was the final diagnosis:

Guillain-Barre Syndrome / Transverse Myelitis / Traumatic Neuritis / Transient Paralysis / Facial Palsy / other / Unknown If other, specify: _____

Use extra sheet of paper to write additional information, if any.

AFP Surveillance

EPID Number:

LABORATORY REQUEST FORM

(To refer stool specimens to polio laboratories)

IND - _ _ - _ _ _ - _ _ - _ _ _

(matches AFP Case Investigation Form)

PART I : Case details to refer stool specimens :

Case Information :

Patient's name : Father's name : _____

Sex : _____ Date of birth : _____/_____/_____ Age : years_____ months_____

Address : _____ Village/City: _____

District : _____ State : _____

Date of onset of paralysis : _____/_____/_____

Total OPV doses received : _____ Date of last dose of OPV (before stool collection) : _____ / _____ / _____

Stool specimen collection :	**Stool 1**	**Stool 2**
Date stool collected	_____/_____/_____	_____/_____/_____
Date stool sent to Lab	_____/_____/_____	_____/_____/_____

Name of the laboratory: _____

Name of person sending the specimen : _____Designation_____

Email id: _____ Mobile / WhatsApp Number: _____

Address : _____

PART II: Receiving at Polio Laboratory :

	Stool 1	**Stool 2**
Date specimens received at laboratory:	_____/_____/_____	_____/_____/_____
Condition of specimens* : (circle)	Good /	Good /
	Good for one time process /	Good for one time process /
	Poor : Leakage /	Poor : Leakage /
	Quantity less /	Quantity less /
	Cold chain breach	Cold chain breach
Lab ID number :	_____	_____

Signature and seal : _____

*** Criteria for "good condition" : adequate volume, no leakage, no dessication and evidence of cold chain maintainance**

ERC-01 Form

NPSP-Unit:

EPID Number: IND - ____ - _____ - _____ - _____

Clinical Record of AFP Case for Expert Review

Name	Age at onset: (months / years)	Sex: Male / Female
Date of 1st Investigation: _____ / ____ / _____; Investigated by_____ Date of 60-day Follow-up: _____ / ____ / _____; Examined by_____		Name & Designation of Officer filling the ERC:
Presenting Complaints [in chronological order] (duration with respect to date of onset): Date of onset of paralysis: _____/_____/_____	1.	2.
3.	4.	5.
Fever at or before onset: Yes / No/ Unknown	History of Injections: Yes / No / Unknown Date of injection: _____ Site & type of injection: _____	Progression of paralysis: Yes / No / Unknown Time taken to develop full paralysis: Hours _____/ Days ____

History of Presenting Illnesses* (From date of onset) H/O trauma H/O loss of consciousness, seizures, diarrhea, vomiting Functional loss suffered by child (Inability to sit / stand / walk/ speak/ etc.) H/o ear discharge or pain / URI / rash / cheek swelling (esp. in case of facial palsy) H/o of birth defects/ birth trauma H/o previous illness / hospitalization Course of illness (Completely recovered / Improving / Static / Deteriorating / Death)	
Immunization History: ROUTINE BCG ☐ Penta/DPT ☐☐☐☐☐ OPV ☐☐☐☐☐ IPV ☐☐ Measles/MR ☐☐ Others (encircle): JE / PCV / Rotavirus / COVID-19 PULSE POLIO DOSES: ☐	Gross motor **Milestones** — Normally achieved by — Age achieved 1 Neck Holding — 3 months 2 Rolling Over — 5-6 months 3 Sitting without support — 6 months 4 Crawling — 7-8 months 5 Standing without support — 12 months 6 Walking — 13 months Give details of **Birth / Neonatal History** (especially if age < 2 years or case of delayed milestones) – Delivery: Home/ Institutional; Normal vaginal / Assisted / LSCS; Delivered at: Preterm / Term / Post-term H/o delayed cry: Yes / No / Unknown Birth weight: ____kg_____ gm; Size (if birth weight not known): Normal / Low / Large size / Unknown **Family H/O:** Consanguinity / Sibling deaths / Abortions / Still births/ Similar disease / Others

Verbal autopsy to be enclosed in death cases

1

EPID Number: IND - ____ - _____ - _____ - _____

Clinical Examination: ***General Physical exam***: State of nutrition	Normal / Underweight / Overweight (Weight: _____Kg)
Any body deformity / Swelling / Tenderness - site(s)	
Joint swelling / Limitation of joint movement	
Bladder / Bowel involvement	
CNS Examination	
• General Observation Behaviour / Activity	
• Posture	
• Gait	
• Mental Status Consciousness Orientation (time, place, person) Speech	Normal / Hoarseness / Nasal twang
• Head (shape and size)	Head circumference: _____ cm (50th percentile value: At birth: 35 cm; 6 mo: 43 cm; 12 mo: 47 cm; 24 mo: 49 cm; 36 mo: 50 cm)
• Neck stiffness	
• Kerning's / Brudzinski's sign	
• Spine	Normal / Tenderness / Deformity / Gibbus / Tuft of hair / Sinus / Swelling
Cranial nerves: I. Olfactory (Smell)	
II. Optic (Acuity of vision, colour vision)	
III. Oculomotor IV. Trochlear VI. Abducens	Pupils/ Eye Movements / Ptosis
V. Trigeminal (Facial Sensation/ Jaw Movements)	
VII. Facial (Asymmetry/ Naso-labial Fold/ Deviation angle of mouth)	
VIII. Cochlear (Hearing)	
IX. Glossopharyngeal X. Vagus	Gag reflex Sucking Swallowing Character of voice
XI. Accessory (Shrugging of shoulder, neck turning)	
XII. Hypoglossal (Tongue Movements)	

EPID Number: IND - ____ - _____ - _____ - _____

Motor Functions:	**Right**	**Left**
Bulk: (Circumference) in cm: Mid-arm		
Mid-forearm		
Mid-thigh		
Mid-calf		
Muscle Tone: Upper limb	**Right** Decreased / Normal / Increased	**Left** Decreased / Normal / Increased
Lower limb	Decreased / Normal / Increased	Decreased / Normal / Increased

Muscle Power:
(grades of weakness from 0 to 5, for each muscle groups)
0 - No Contraction
1 – Flicker of contraction
2 – Active movement with gravity eliminated
3 – Active Movement against gravity but no resistance
4 - Active Movement against some resistance
5 – Normal

UPPER LIMB

SHOULDER	Right	Left
Flexion	____ / 5	____ / 5
Extension	____ / 5	____ / 5
Abduction	____ / 5	____ / 5
Adduction	____ / 5	____ / 5

ELBOW	Right	Left
Flexion	____ / 5	____ / 5
Extension	____ / 5	____ / 5

WRIST	Right	Left
Flexion	____ / 5	____ / 5
Extension	____ / 5	____ / 5
Abduction	____ / 5	____ / 5
Adduction	____ / 5	____ / 5
Grip	____ / 5	____ / 5

Neck	No contraction (0) / Some weakness (1- 4) / Normal (5)
Trunk	No contraction (0) / Some weakness (1- 4) / Normal (5)

LOWER LIMB

HIP	Right	Left
Flexion	____ / 5	____ / 5
Extension	____ / 5	____ / 5
Abduction	____ / 5	____ / 5
Adduction	____ / 5	____ / 5

KNEE	Right	Left
Flexion	____ / 5	____ / 5
Extension	____ / 5	____ / 5

ANKLE	Right	Left
Dorsiflexion	____ / 5	____ / 5
Plantarflexion	____ / 5	____ / 5
Inversion	____ / 5	____ / 5
Eversion	____ / 5	____ / 5

Face	Weakness (0 - 4) / Normal (5)

Reflexes: (*Grades*):
A: Absent
N: Normal
↓ Diminished
↑-Brisk
U: Uncooperative

	Right	Left
Triceps		
Biceps		
Supinator		

	Right	Left
Knee		
Ankle		
Plantar reflex	Flexor / Extensor / Equivocal / Absent / Uncooperative	Flexor / Extensor / Equivocal / Absent / Uncooperative

Trophic changes: Ulcers / Bedsores (if yes, give details)		
Cerebellar signs / Coordination	Finger-nose test / past-pointing Dysdiadochokinesia:	Heel-knee test/ Tandem walking
Involuntary movements: Tremors / Convulsions / Chorea		
Sensations: Superfical / Tactile / Pain/ (any sensory level)		

EPID Number: IND - ____ - _____ - _____ - _____

Other systems CVS: Respiratory: Abdomen: Others:		
RESIDUAL WEAKNESS ON 60 DAYS FOLLOW-UP	**YES / NO**	
Laboratory Tests: *(List reports whichever available)* Hematology: Urine: Stool: S. Electrolytes: Blood Sugar: CSF: Serology: Others:		
Radiology: *(fill exam. Reports, if available)* X-rays CT scan: MRI: Ultrasonography: Nerve Conduction Velocity: Electromyogram: Others: **Hospitalization:** Name of Hospital Date Hospital Diagnosis **If child died:** Cause of death Date of death / Place of death (Health facility / home)	Yes / No _____ From _____ to _____ Provisional: _____; Final: _____	
Pediatric / Any physician evaluation / Diagnosis Date	_____ _____/_____/_____	
Probable Diagnosis	1. 2	Signature: Date:

Note: 1. Clinical evaluation using ERC-01 form should be done after 60 days of onset of paralysis (in death cases as soon as possible); preferably within 70 days of onset of paralysis
2. This form should be used to supplement the clinical information obtained on initial case investigation.
3. The copies of hospital/medical records/ reports of investigation should be attached.

ERC-02 Form

Photograph / Video Form for Expert Review AFP Case Classification

(Kindly paste a photograph on this sheet)

EPID Number: IND ____ _____ _____ _____

Name of the AFP case: _____

Age_____ Sex: M / F

Date photographs taken*: ____/____/_____

Date videos made*: _____/_____/_____

No. of photographs enclosed**: _____ No. of videos sent / uploaded**: _____

Reason for not taking the photograph/video(s):

*Please click 2-4 photographs showing all limbs and paralyzed part clearly & make 1-2-minute sho video

**For digital uploading - Upload photographs in 'pdf' format and videos in 'MP4' format

Format for Approval of Special tests		ERC-03 Form
SMO Name		**Remarks by SMO**
EPID Number	IND ____ _____ _____ _____	
Details of the case (Name/Age/Gender)		
Place of testing		
Plan of travel		

Cost Estimate				
Details	**Rate**	**No. of persons**	**No. of days**	**Remarks & Signature of SMO**
Test Costs				
Per diem (only for guide, if reqd.)				
Cost of travel				
Boarding/Lodging				
Total				

Approval by WHO NPSP India Office

Neurological Assessment Form for AFP Case

EPID NUMBER: IND_____ _____ ____ _____

NPSP Unit: _____ Name of SMO: _____

Name of the Specialist: _____

Date of examination by the Specialist: ____/____/_____

Patient Name:_____ Age: ___mo____yr Sex: M / F

Address:

Brief Clinical History

General Physical Examination

State of nutrition: Normal / Underweight / Overweight (Weight: _____Kg)

Neurological Examination

1. Consciousness:
2. Alertness:
3. Physical Attitude:
4. Any body deformity:
5. Developmental milestones:
6. Speech:
7. Cranial Nerves:

8. Fundus:

9. Limb circumference measurements (cm)

Limb circumference	Right	Left
a) Mid-arm (Acromion process to Olecranon process)		
b) Mid-forearm (Olecranon process to Pisiform bone)		
c) Mid-thigh (Anterior superior iliac spine to Medial condyle)		
d) Mid-calf (Medial condyle to Medial Malleolus)		

10. **Motor system** **Right** **Left**

- Tone
  - Upper Limb
  - Lower Limb
- Muscle Power (grading 0 to 5)

SHOULDER
Flexion
Extension
Abduction
Adduction

ELBOW
Flexion
Extension

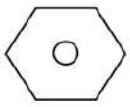
WRIST
Flexion
Extension
Abduction
Adduction
Grip

HIP
Flexion
Extension
Abduction
Adduction

KNEE
Flexion
Extension

ANKLE
Dorsiflexion
Plantarflexion
Inversion
Eversion

Trunk
Neck

11. Reflexes
    - Superficial
        * Abdominal 
        * Plantar — Right / Left
        *Cremasteric
    - Deep tendon reflexes

	Biceps	Triceps	Supinator	Knee	Ankle
Right Left					

Clonus:

12. Sensory System
    - Touch
    - Pain
    - Temp
    - Vibration
    - Position
13. Extra Pyramidal Signs
14. Cerebellar Signs
15. Coordination
16. Abnormal Movements
17. Meningeal Signs - NR/KS:
18. Gait
19. Examination of Spine

Skull

20. Electrophysiological studies

A) NCV Study:
B) EMG Study:

21. Clinico Electro Physiological Diagnosis

Date: _____ Signature: _____

ERC-05 Form

VERBAL AUTOPSY FORM FOR REPORTED AFP DEATH CASE

EPID NO. IND - ____ -_____ -____- _____

Interview deceased case's parent / caregiver & treating physician

1 Details of deceased

- Name:
- Age _____ Yr _____ month (DOB: ____/_____/_____) Sex: M / F
- Date and Time of death: ___ / _____ / _____; _____:_____ AM / PM
- Place of death: Home / Hospital / On way to health facility/Unknown

2 Details of respondent

- Name:
- Relationship of respondent with deceased:
- Did the respondent live with patient during events that led to death? Yes / No
- What did the respondent think the patient died of? _____

Please encircle appropriate answers wherever required

3 Birth history (especially if patient is <2 years of age):

a.	Where was child born?	Home	Hospital		Other
b.	What was the mode of delivery?	Vaginal	LSCS		Assisted
c.	Indication of LSCS / Assisted delivery: _____				
d.	Any complications during pregnancy or birth	Yes	No		Unknown
e.	If yes, please elaborate: _____				
f.	How many months long was the pregnancy: _____				
g.	Did the baby cry immediately after birth	Yes	No		Unknown
h.	What was the baby's size at birth?	Small	Average	Large	Unknown
i.	What was the birth weight?	_____kg	_____gm		
j.	Any congenital malformation?	Yes	No		Unknown
k.	When was s/he first breastfed?	_____			
l.	Did the child receive anything other than breast milk during first 6 month of life?	Yes	No		Unknown / NA
m.	During the illness that led to death, did the child stop breastfeeding?	Yes	No		Unknown / NA
n.	Any still birth/ abortion in previous pregnancies?	Yes	No		Unknown

4 Developmental history

a.	Was the child growing physically and mentally at par with other children of his/her age?	Yes	No	Unknown
b.	Did the child achieve age-appropriate milestones?	Yes	No	Unknown

5 Family history

a.	H/O consanguinity	Yes	No	Unknown
b.	H/O tuberculosis in family	Yes	No	Unknown
c.	H/O similar disease in family	Yes	No	Unknown

VERBAL AUTOPSY FORM FOR REPORTED AFP DEATH CASE

EPID NO. IND - ____ -_____ -____- _____

6 Details of sickness at time of death

1	Fever	Yes	No	Unknown
2	If yes, mention the duration of fever?	_____		
3	Chills / rigors	Yes	No	Unknown
4	Seizures	Yes	No	Unknown
5	Loss of consciousness	Yes	No	Unknown
6	Stiffness of body	Yes	No	Unknown
7	Neck stiffness	Yes	No	Unknown
8	Excessive crying / irritability	Yes	No	Unknown
9	Lethargic	Yes	No	Unknown
10	Poor feeding	Yes	No	Unknown
11	Diarrhea	Yes	No	Unknown
12	Dysentery	Yes	No	Unknown
13	If child had diarrhea, mention its duration?	_____		
14	Was the child given oral / intravenous rehydration therapy	Yes	No	Unknown
15	Cough	Yes	No	Unknown
16	If yes, mention the duration of cough?	_____		
17	Did the child cough out blood?	Yes	No	Unknown
18	Vomiting	Yes	No	Unknown
19	If yes, mention the duration of vomiting?	_____		
20	Did the child vomit out blood?	Yes	No	Unknown
21	Breathing difficulties	Yes	No	Unknown
22	If yes, mention the duration of breathing difficulties?	_____		
23	Fast breathing	Yes	No	Unknown
24	Chest indrawing	Yes	No	Unknown
25	Cyanosis	Yes	No	Unknown
26	Wheezing	Yes	No	Unknown
27	Abdominal pain	Yes	No	Unknown
28	Abdominal distension	Yes	No	Unknown
29	Yellowness of eyes / skin	Yes	No	Unknown
30	Loss of appetite	Yes	No	Unknown
31	Paleness of eyes / skin	Yes	No	Unknown
32	Skin rash	Yes	No	Unknown
33	Redness of eyes	Yes	No	Unknown
34	History suggestive of measles	Yes	No	Unknown
35	Preceding death, did the child become very thin	Yes	No	Unknown
36	Preceding death, did the child have swelling of hands, feet or abdomen?	Yes	No	Unknown
37	During the course of illness did the child receive antibiotics?	Yes	No	Unknown
38	Difficulty in swallowing	Yes	No	Unknown
39	Nasal regurgitation of fluids	Yes	No	Unknown
40	Nasal intonation / change in voice	Yes	No	Unknown
41	Was the child diagnosed with COVID-19?	Yes	No	Unknown
42	If yes, then write the date of diagnosis _____ /_____ /_____			
43	Did child have multiple illnesses?	Yes	No	Unknown

ERC-05 Form

VERBAL AUTOPSY FORM FOR REPORTED AFP DEATH CASE

EPID NO. IND - ____ -_____ -____- _____

44 If yes, what were the symptoms of these illnesses? _____

45 Any significant injury or accident prior to death? Yes No Unknown

46 What was the status of paralyzed parts of body before death? Recovered / Improving / Static / Deteriorating

Interviewer's narration (Case summary)

(a) Describe symptoms in chronological order, doctor consulted, any hospitalization, history of similar episodes, events leading to death, etc.

(b) On the basis of verbal autopsy what is the immediate cause of death and does it seem to be related to paralysis? Please elaborate and give reasons for the same

7 Post-mortem examination done: Yes No Unknown
(If yes, then attach all postmortem reports)

8 Conclusions

- Respondent's cooperation Good Poor
- Interviewer's name and designation: _____
- Date of interview: _____/_____/ _____
- Clinical impression: _____

Interviewer's signature

ERC-06 Form

CHECKLIST FOR SENDING EXPERT REVIEW COMMITTEE DOCUMENTS FOR AFP CASE CLASSIFICATION

Tick mark the purpose of documentation **Date docs sent/uploaded*: ____/____/_____**
(Tick both for inadequate case with vaccine virus in stool)

Inadequate case for ERC classification ☐ **Poliovirus isolated in stool specimen** ☐

Name of SMO / DIO : _____ **EPID No: IND _____ _____ ___ ____**

	Sent / Uploaded	Not Sent / Not Uploaded (give reasons)	Remarks
Completed CIF			
ERC-01 Clinical Record Form			
ERC-02 Photograph/ Video Form			
ERC-03 Approval Request Form			
ERC-04 Neurological Assessment Form**			
ERC-05 Verbal Autopsy Form in death cases			
Hospital Records / Reports / Prescriptions /			
Interview of attending physician / pediatrician			
Photograph &Video Digitally uploaded***/ CD enclosed			

*Small files with size up to 1 MB need not to be zipped/compressed while uploading
**To be filled by the Pediatrician/ Pediatric Neurologist / Neurologist
*** Upload photographs in 'pdf' format and videos in 'MP4' format

Note: This sheet should accompany any information / documents being sent to NPSU

NPSP-Unit:

Record of NON-AFP CASE FOR REJECTION

EPID NUMBER: IND ____ _____ ____ ____	Name:	Age at onset: (months / years) Sex: Male / Female	Name & Designation of Notifying person: Date of Notification: ___/___/___
Date of onset of paralysis: ____/_____/_____	Name & Designation of Verifying Medical Officer:		Date of Verification: ___/____/___
History of present illness:*			
Clinical Examination:			
Reason for Rejection:			
Provisional Diagnosis of Non-AFP Case:			

Send an appropriately taken photograph / short video of the case

Signature of SMO/Verifying Medical Officer

Note: *In case of Delayed Milestones, mention Birth/Neonatal History

Attach any relevant document if available (Hospital Record/Pediatrician or Specialist opinion)

AFP Case and Stool Sample Tracking Register

Page:

AFP CASE & STOOL SAMPLE TRACKING (Page 1)

Sl. No.	Date, case reported	Name of case	Father's Name & Address of case with complete details including telephone no.	Reported by (with details including telephone number if any)	Investigated by (with designation and date)	AFP ? Yes / No	IF AFP , EPID number	Date of ONSET	Person / s collecting / overseeing stool collection (with designation and telephone number)	Reporting District	If cross notified then details
											Date: ……… District Name : ……… **District of residence:** ……… Mode: ………
											Date: ……… District Name : ……… **District of residence:** ……… Mode: ………
											Date: ……… District Name : ……… **District of residence:** ……… Mode: ………
											Date: ……… District Name : ……… **District of residence:** ……… Mode: ………

AFP CASE & STOOL SAMPLE TRACKING (Page 2)

Page:

Stool Collection tracking ("√" & fill the response)					Date of stool samples reaching the District office from where shipment is made	Date of shipment of stool with condition	Reasons for delay / stool not collected	ORI / ACS done (Y/N) / Date	Information on feedback	Remarks
day 1	day 2	day 3	day 4	day 5						
Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person bringing to office: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person bringing to office:	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person shipping to lab: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person shipping to lab:		ORI ACS	Stool result given: 1. To parents: Date:.......... Mode: 2. To Reporting Site: Date:.......... Mode: 3. To PHC / UA: Date:.......... Mode:	
Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person bringing to office: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person bringing to office:	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person shipping to lab: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person shipping to lab:		ORI ACS	Stool result given: 1. To parents: Date:.......... Mode: 2. To Reporting Site: Date:.......... Mode: 3. To PHC / UA: Date:.......... Mode:	
Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person bringing to office: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person bringing to office:	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person shipping to lab: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person shipping to lab:		ORI ACS	Stool result given: 1. To parents: Date:.......... Mode: 2. To Reporting Site: Date:.......... Mode: 3. To PHC / UA: Date:.......... Mode:	
Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date........ □ Stool kit + VC given □ Stool 1 collected □ Stool 2 collected Time of stool collection .... Place of collection: .... □ Ice Pack given / replaced □ Stool not collected Others.......... .... Sign..........	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person bringing to office: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person bringing to office:	Date S 1: Time S 1: Quantity: Ice packs: LRF: Person shipping to lab: .... Date S 2: Time S 2: Quantity: Ice packs: LRF: Person shipping to lab:		ORI ACS	Stool result given: 1. To parents: Date:.......... Mode: 2. To Reporting Site: Date:.......... Mode: 3. To PHC / UA: Date:.......... Mode:	

CIF – iVDPV

CASE INVESTIGATION FORM
:iVDPV Surveillance in Persons with Primary Immunodeficiency

EPID Number:
IND - __ - __ - ___ - ___
(matches Lab Request Form)

1. Case Notification and Investigation

Notifying Hospital: _____Date of notification: ___ / ____ / _____
Physician Name:_____Physician Phone Number : _____
Case investigated by: _____ Designation: _____
Date of investigation: ___/____/_____

2. Case Identification

Patient Name: _____ Other names:_____
Sex: Male / Female Date of birth: ___ /___ /_____ Age: _____ Yr _____ Month
Father Name: _____Mother Name:_____
Father Occupation:_____ Religion: H / M / O Caste:_____
Grandfather name: _____ Address: _____
Landmark:_____ Village / Mohalla: _____
Block / Urban area: _____District: _____Setting: Urban / Rural
State: _____ Tel/Mobile: _____
ID No. ( ) _____
Child belongs to migratory family / Tribal Community: Yes/ No/ Unknown
If yes, specify: Slum with migration/Nomad/Brick Kiln/Construction site/ Tribal / Others/(Specify): ____

3. Immunization History

Type of poliovirus vaccine received by patient: OPV/ IPV/ Both
Number of OPV doses through RI (a): ____ Number of OPV doses through SIA (b): ____
Total OPV doses (a+b): _____
Date of last dose of OPV (at the time of first investigation): _____/_____/_____
Date of last dose of OPV (before stool collection): ____/____/_____
Date of recent exposure to OPV for close contacts (in last 6 months): ____/____/____
Date of last OPV campaign in community: ___/____/_____
Number of IPV doses received: 0 / 1 / 2 / 3 / Unknown Source of RI data: RI card / Recall / both
If RI card, has it been marked that child should not receive OPV through RI / SIA: Yes / No

4. Medical History

Date of first consultation as a suspect PID: ___/___/____ Date of confirmation of PID: ___/___/___
Age at diagnosis of PID: _____ years _____ months
PID diagnosis as per latest International Union of Immunological Societies (IUIS) [encircle correct one):

a. Severe Combined Immunodeficiency Disorder (specify): _____
b. Combined Immunodeficiency Disorder with or without syndromic features (specify): _____
c. Antibody deficiencies i. Agammaglobulinemia, ii. CVID iii. Others (Specify): _____
d. Other PID (specify): _____

IVIG treatment: Yes / No Bone marrow transplant: Yes / No
Acute flaccid paralysis (AFP): Yes / No If AFP, Date of onset of paralysis: _____/_____/_____
AFP EPID number _____
*Site(s) of Paralysis (encircle): right arm / left arm / right leg / left leg / neck / bulbar / respiratory muscle / trunk / facial/ other*_____

OPV: Oral Poliovirus Vaccine; IPV: Inactivated Poliovirus Vaccine; RI: Routine immunization; SIA: Supplementary immunization activity (pulse polio); PID: Primary Immunodeficiency; CVID: Common Variable Immunodeficiency; AFP: Acute Flaccid Paralysis; Identification Number Code: 1 - Aadhaar card, 2 - Voter Card, 3. PAN, 4. Passport, 5. Driving license number, 6. National Health ID, 7. State Health ID, 8. Other

5. Stool Specimen Collection

Date collected Date sent Date of result Condition Lab result (circle)

1st sample ___/___/____ ___/___/____ ___/___/____ Good/Poor P1 P2 P3 WPV SL VDPV NPEV NEG

Name of the laboratory: _____ *Reason: _____

2nd sample ___/___/____ ___/___/____ ___/___/____ Good/Poor P1 P2 P3 WPV SL VDPV NPEV NEG

Name of the laboratory: _____ *Reason: _____

*Reason if both stool specimen not collected within 7 days of notification: Late investigation / Delay in sample collection / Constipation / Death / Lost / Other _____

Follow-up Specimen

Sample no.	Due date for sample collection	Sample Collection Date	Date Sample Sent to lab	Date of Lab Result	Last OPV dose	Last SIA round	Laboratory name	**Reason for late sample collection	Condition of sample (Good / Poor)	#Final Result

#Final Result: P1 P2 P3; WPV SL VDPV; NPEV; NEGATIVE (Example: P1 VDPV *OR* P3 SL *OR* NPEV *OR* NEGATIVE)

**Reason if follow-up specimen not collected within 7 days of due date: Lack of tracking / Constipation / Death / Lost / Other _____ ; *If death, mention the date of death:* ____/____/_____

Are contact specimens collected? Yes / No

Date of collection: First sample ____/____/_____ Last sample ____/____/_____

Number of contact specimens collected: ____;

SL positive_____ VDPV positive_____ WPV positive_____

NPEV positive_____ Negative____

6. Case Classification

Final classification: Type-1: SL / WPV / VDPV; Type-2: SL / WPV / VDPV; Type-3: SL / WPV / VDPV; NPEV positive / No Enterovirus / pending results

Is the person eligible for antiviral polio treatment? Yes / No; Antiviral treatment requested? Yes/No

If yes, treatment dates: Start ___/____/____ End __/___/_____

Type of antiviral (Specify): _____ Compliance: Full dose / partial / not taken

- Use extra sheet of paper to write additional information, if any.
- Collect all the relevant medical records at the time of investigation
- *PPD: Patient with Primary Immunodeficiency; iVDPV: Immunodeficiency-related Vaccine Derived Poliovirus; SL: Sabin-Like; WPV: Wild Poliovirus; NPEV: Non-polio Enterovirus*

Suspected MR-CIF

Case Investigation Form (CIF) for Suspected Measles / Rubella

MR EPID Number: MR-IND-____-____-_____-_____ (Matches with Laboratory Request Form)

1. Type of Case: Sporadic / Outbreak, [If case belongs to an outbreak then please provide a linked MOB-ID (MOB- IND-BI- AGB- _____-_____)

2. Notification / Investigation Information:

Date Case Notified: _____/_____/_____ Notified by: _____ Designation: _____

Date Case Investigated: ____/____/____ Investigated by:_____ Designation: DIO/DSO/Medical Officer/ Nodal Officer/ SMO/ Other

Date case verified: _____/_____/_____ Verified by:_____ Designation: DIO/DSO/Medical Officer/ Nodal Officer/ SMO/ Other

Notifying Health Facility Type: RU/ Informer/ Other **Category**: VHP/ HP/ LP/ Other **Setup**: Govt. Allopathic/ Pvt Allopathic/ ISM Pract./ Quack/ HW / HSC /HWC/FLW/ Others

3. Case Identification: Patient's Name: _____ other given names: _____

Sex: M / F Date of birth: _____/_____/_____ Age: years_____ months_____

Father's Name:_____ Mother's Name:_____

Father's Occupation:_____ Grand father's Name:_____

Address : _____ Landmark:_____ Religion: Hindu / Muslim / Other

Planning unit (PHC/UPHC): _____ Village / Mohalla: _____ HRA: Y / N

Panchayat/Ward No: _____ **Caste:** _____ **ID No:**( )_____

Block /Urban area: _____ District: _____ Setting: Urban / Rural

State: _____ **Pin Code:**_____ Mobile _____ mail ID :_____)

Patient belongs to migratory family/ community : Yes/ No If yes, specify: Slum with migration / Nomad / Brick Kiln / Construction site / Other migratory : _____

4. Hospitalization: Yes / No Treated at OPD/ IP Date of Hospitalization:____/____/____ IP No. _____

Name of Hospital:_____ Diagnosis as per hospital records, if any: _____

5. Immunization History: Measles containing vaccine received: Yes/ No/ Unknown/ NA If yes, vaccination history as per: MCP card/Recall/both

Measles containing vaccine(MCV) received through RI :

a. MCV 1: Y / N / Unknown / NA ; **Type**: M/MR/MMR/MMRV/Unknown If card available, date ____/____/_____

b. MCV 2: Y / N / Unknown / NA **Type**: M/MR/MMR/MMRV/Unknown If card available, date ____/____/_____

If MCV is missed in RI ,specify reason: Awareness gap / AEFI apprehension / Child travelling / Operational gap / refusal / others _____

c. No. of MCV doses received through campaign (SIA): _____ Total MCV doses (RI+SIA): 0 / 1 / 2 / 3 / 4 / more

If campaign dose is missed, encircle reason - Awareness gap / AEFI apprehension / Child travelling / Operational gap / refusal /campaign not held/ others _____

Date of last dose of MCV (before rash onset): _____/_____/_____ (to be filled in line list)

Date of last dose of MCV (before blood collection): _____/_____/_____ (to be filled in LRF)

6. Clinical History: Generalised Maculopapular Rash : Yes / No / Unknown **Date of Rash Onset:**____/____/____

Fever : Yes / No / Unknown Date of fever onset : ____/_____/_____

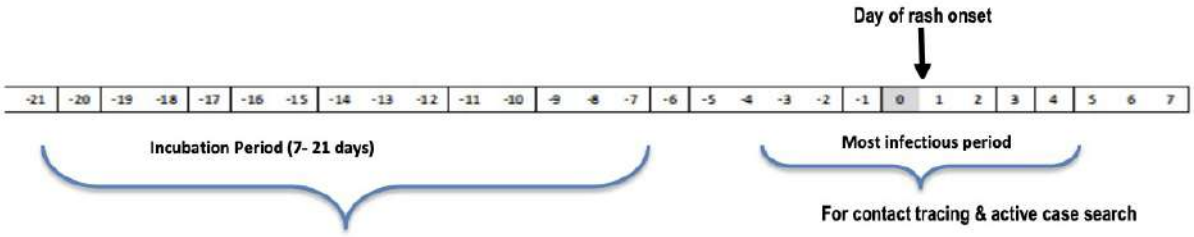
Cough : Yes / No Coryza (Running Nose) : Yes / No Conjunctivitis (Red eyes) :Yes / No Clinician suspects Measles: Yes / No

Enlarged lymph nodes : Yes / No Joint pain : Yes / No Clinician suspects Rubella : Yes / No

Complications : Yes / No If yes: Diarrhea / Malnutrition / Encephalitis / ARI / Pneumonia / Ear problems (otitis media), Eye problems (corneal clouding / xerosis) / others (Please specify)

No. of Vitamin-A doses received: 0/1/2 (If 0/1 then advise to complete 2 doses of Vit A 24 hours apart) Malnutrition (in child <5 years): Y/ N

7. Travel History: Yes / No Travel of case within 21 days prior to onset of rash (indicate dates and place of travel with arrows on date line)



District of residence: _____

(Based on maximum stay during incubation period, if multiple districts are involved)

Requires cross notification? Yes / No

If yes, date of cross notification: ____/____/_____

Block/ Urban area of residence: _____

Places visited during most infectious period: _____

8. History of similar symptoms among close contacts:

Similar symptoms in other household contact(s): Yes / No If yes, No. affected: _____ Name/s: _____

Similar symptoms in other neighbourhood / work / school contact(s): Yes/No If yes, No. affected: _____ Name/s: _____

If any of the above contact is already lab confirmed, mention EPID No : _____

CIF contains two pages, both pages must be filled for all suspected MR cases

Identification Number Code: 1 - Aadhaar card, 2 - Voter Card, 3. PAN, 4. Passport, 5. Driving licence number, 6. National Health ID, 7. State Health ID, 8. Other

MR CIF (Page 2) **MR EPID No.:** MR-IND-___-___-____-_____

9. Health seeking behaviour after rash onset (encircle): confined at home / contacted community workers / contacted health facility

10. If history of contact with community workers after the date of rash onset , mention details:

Name	Specify category of community workers	Date of contact	Did they refer / report the case to any facility	Action by DIO / SMO/ MO
1	Health workers / Religious leader /Community influencer	____/____/_____	Yes / No	
2	Health workers / Religious leader /Community influencer	____/____/_____	Yes / No	

Categories of Community workers : Health Workers - ANM /CHO/AWW/ASHA/LHV/MPW , **Religious leaders :** Priest / Temple link person/ Mazars/Maulana / Ozha **Community influencers** : Village head / Teacher/ Pradhan/ Panchayat member

11. If history of contact with healthcare providers after the date of rash onset (including the notifying health facility), mention details:

Name, mobile number and address of Health Facility (Hospital/ doctor/ quack/other):	1	2	3	4
Date case visited:				
Already RU/informer?	Yes / No	Yes / No	Yes / No	Yes / No
Did the HF report this case?	Yes / No	Yes / No	Yes / No	Yes / No
Action taken by SMO / DIO / MO				
Date feedback given to health facility				

12. Provisional diagnosis:

Suspected Measles / Suspected Rubella / Others if Others Specify _____

13. Specimen Collection: Yes / No (Blood from suspected case within 28 days of rash onset; Any one of throat swab / nasopharyngeal swab / urine sample within 7 days of rash onset)

For Serology	Date Collected	Date Sent	Date of Result	Condition	Laboratory Result* (circle)	
Blood	__/__	__/__/__	__/__/__	Good / Poor	**IgM Positive (M / R) / IgM Negative (M / R)**	

If sample is not collected **within 28 days of rash onset** then encircle reason. Late Notification/ Late investigation/ Delay in sample collection / Parent denial / Death / Lost/ Other

For Virology (any one)	Date Collected	Date Sent	Date of Result	Condition	Laboratory results
1.Throat Swab	__ / __ / __	__ / __ / __	__ / __ / __	Good / Poor	**Measles virus (_____) / Rubella virus (_____) / Negative**
2. Nasopharyngeal swab	__ / __ / __	__ / __ / __	__ / __ / __	Good / Poor	**Measles virus (_____) / Rubella virus (_____) / Negative**
3. Urine sample	__ / __ / __	__ / __ / __	__ / __ / __	Good / Poor	**Measles virus (_____) / Rubella virus (_____) / Negative**

If sample is not collected **within 7 days of rash onset** then encircle reason. Late Notification / Late investigation / Delay in sample collection / Parent denial / Death / Lost / Other

14. Name of Govt Health Facility resposible for Active Case Search and public health response in neihbourhood community (scanning of area by HW /FLW):

_____

Active case search in community done: Yes / No If yes, Date of search: ____/____/_____ Number of suspected cases found: _____

15. Feedback:

Patient / Caregiver: Mobile:_____ Email Id:_____ Date Given: ___/___/____

Reporting Person / Institution: Mobile:_____ Email Id:_____ Date Given: ___/___/____

16. 30 Day Follow-up: Date of follow-up: ____/____/_____ if not done give reason:_____ Outcome: Alive / Death / Lost

If died, date of death: ___/___/___ cause of death: _____ Complications present: Yes/No

Type of complications:Diarrhea / Pneumonia / Encephalitis/ Ear infection / Eye complications / Skin complications / Co-morbid conditions / Others _____

17. If the suspected case is Pregnant: Yes / No, if pregnant please record EDD & observation during 30-day followup, for future CRS outcomes once again at EDD

18. At the time of EDD, follow up if CRS is suspected, then specify observation after delivery / end of pregnancy: Spontaneous abortion / MTP / Still birth

Date visit made to newborn from infected mother:____/____/_____ Newborn Status: Normal / Birth defect

If New born has birth defects then please encircle : Congenital heart defect / Eye defect / Hearing defect / Neurological deficit / Endocrine deficit / Other deficits

19. Final Classification:	**Measles / Rubella / Discard**
	Lab-confirmed / Epi-linked/ Clinically-Compatible

RU-Reporting unit, **VHP**-Very high priority, **HP**-High priority, **LP**-Low priority, **HW**-Health worker (ANM/MPW/LHV/Health Inspector/Supervisor etc.), **HSC**-Health sub center, **HWC**-Health and Wellness Centre, **FLW**-Front line worker (ASHA/AWW), **EDD**-Expected date of delivery,**CRS**-Congenital rubella syndrome,**MTP**-Medical termination of pregnancy

* Equivocal to be considered as positve

Form VPD-MR-LRF

MR LABORATORY REQUEST FORM
(for sporadic cases)

EPID Number: MR-IND-

PART I : Case Information

Patient name:_____ **Fathers Name:**_____

DOB/ Age:_____ **Years:**_____ **Months:**_____

Sex: M /F **Date of rash onset:** _____

MRCV received: Y/N **If yes,date of last MRCV dose:**_____

State:_____ **District:**_____ **Block:**_____ **PHC/ UPHC:**_____

Address:_____

Specimen collection :	Type of specimen	Date specimen collected	Date specimen sent
Please collect	Serum	_____	_____
	Throat swab	_____	_____
	Urine	_____	_____
	Nasopharyngeal swab	_____	_____

Name of the laboratory: _____

Name and designation of person sending the specimens:_____

Email id: _____ Mobile / WhatsApp Number: _____

Address:_____

PART II :Receiving at Laboratory

Type of specimen	**Lab ID Number**	**Date specimen received**	**Condition of specimen**	**Result**		**Remarks (if any)**
				Measles	Rubella	
Serum			Good / Poor			
Throat swab			Good / Poor			
Urine			Good / Poor			
Nasopharyngeal swab			Good / Poor			

Receiving laboratory name:_____ Signature:_____

Note: 1. Serum specimen should be collected within 28 days of rash onset;
2. Any one among (Throat Swab / Urine/ Nasopharyngeal swab) should be collected within 7 days of rash onset
3. Label on each specimen must include: (1) MR Epid Number (2) Specimen type

*** Case number should exactly match with case number in "MRCIF"**

MR LABORATORY REQUEST FORM (for outbreaks)

Address: _____ Outbreak ID ## : _____

State:_____ District:_____ Block/ Urban area:_____ PHC/ UPHC:_____

Case information									To be filled out by receiving laboratory			
Patient name	Case number* (if outbreak)	Specimen Type (encircle one)**	DOB/ Age		Sex	Date of rash onset	Date of last measles containing vaccine dose	Specimen collection date	Condition of specimen	Result		Remarks (if any)
			Years	Months	M / F					Measles	Rubella	
	_ _ _	S / T / U / N							Good / Poor			
	_ _ _	S / T / U / N							Good / Poor			
	_ _ _	S / T / U / N							Good / Poor			
	_ _ _	S / T / U / N							Good / Poor			
	_ _ _	S / T / U / N							Good / Poor			
	_ _ _	S / T / U / N							Good / Poor			
	_ _ _	S / T / U / N							Good / Poor			

Date specimens sent:_____

Name of the laboratory: _____

Name and designation of person sending the specimens:_____

Email id: _____ **Mobile / WhatsApp Number:** _____

Address:_____

Date specimens received:_____

Receiving laboratory name:_____

Signature: _____

Note: 1. Serum specimen should be collected within 28 days of rash onset

2. Any one among (Throat Swab / Urine/ Nasopharyngeal swab) should be collected within 7 days of rash onset

3. Each specimen label must include: (1) Outbreak ID / MR Epidnumber; (2) Case Number; (3) Specimen type;

*** Case number should exactly match with case number in "VPDOB003" linelist format and specimen label.**

**** Specimen type: S= serum; T=Throat Swab; U=Urine;N=Nasopharyngeal swab**

EPID number to be created based on Outbreak ID and Case number

MR Outbreak Investigation (OB 003)

MR OUTBREAK INVESTIGATION: Information regarding suspected MR cases (OB 003)

(to be filled during detailed outbreak investigation and continued to be updated till the closure of MOB)

Outbreak ID: MOB-IND - _____
(To be filled by health supervisor/MOIC)

Team No._____

District/Corpn.:_____Block/Ward/Zone: _____PHC/UPHC:_____ Sub center/ANM area:_____Village/Urban area (mohalla): _____Setting: Urban / Rural

Panchayat/Ward No._____ HRA area: Yes/No, If yes, HRA type: # Encircle code 1/2/3/4/5/6A/6B/6C/6D/6E Index case notification date ___/___/___ Date of HTH search: ___/___/___

ANM name & Mobile No:_____ Medical officer name:_____ Names of person conducting:_____ Date report sent: ___/___/___

Particulars	Number of Fever Maculopapular Rash cases	1	2	3	4
Identifiers	EPID Number (not to be filled by team)				
	Case Name:				
	Father's/Husband's Name:				
	Father's Occupation				
	Mother's Name				
	Grand Father Name				
	ID of patient / either of parents				
	Address:				
	Landmark				
	Pin code				
	Telephone:				
	Gender: M/F	M/F	M/F	M/F	M/F
	Religion & caste	H/M/O Caste:_____	H/M/O Caste:_____	H/M/O Caste:_____	H/M/O Caste:_____
	DOB (dd/mm/yyyy):	__/__/__	__/__/__	__/__/__	__/__/__
	Age (in years and months)	___year;___month	___year;___month	___year;___month	___year;___month
Immunization History	MCP Card available	Y/N	Y/N	Y/N	Y/N
	MRCV Received: Yes(Y) / No (N)/ Unknown (U)/ Not applicable (NA); If Yes, received through RI/ SIA/ Both (encircle)	Y / N / U / NA RI/ SIA/ Both	Y / N / U / NA RI/ SIA/ Both	Y / N / U / NA RI/ SIA/ Both	Y / N / U / NA RI/ SIA/ Both
	If received through RI, encircle vaccine details.	1st dose: M / MR / MMR / MMRV 2nd dose: M / MR / MMR / MMRV	1st dose: M / MR / MMR / MMRV 2nd dose: M / MR / MMR / MMRV	1st dose: M / MR / MMR / MMRV 2nd dose: M / MR / MMR / MMRV	1st dose: M / MR / MMR / MMRV 2nd dose: M / MR / MMR / MMRV
	If received through SIA, fill details: M / MR / MMR / MMRV	M / MR / MMR / MMRV	M / MR / MMR / MMRV	M / MR / MMR / MMRV	M / MR / MMR / MMRV
	Date of last MCV/MR vaccine before rash onset (dd/mm/yyyy)	__/__/__	__/__/__	__/__/__	__/__/__
	Date of last MCV/MR vaccine before blood collection (dd/mm/yyyy)	__/__/__	__/__/__	__/__/__	__/__/__
Clinical History	Fever: Yes(Y) / No (N)/ Unknown (U); If yes, mention onset date	Y/N/U; onset date __/__/__	Y/N/U; onset date __/__/__	Y/N/U; onset date __/__/__	Y/N/U; onset date __/__/__
	Rash: Yes(Y) / No (N)/ Unknown (U); If yes, mention onset date	Y/N/U; onset date __/__/__	Y/N/U; onset date __/__/__	Y/N/U; onset date __/__/__	Y/N/U; onset date __/__/__
	Cough: Yes / No	Y / N	Y / N	Y / N	Y / N
	Coryza: Yes / No	Y / N	Y / N	Y / N	Y / N
	Conjunctivitis: Yes / No	Y / N	Y / N	Y / N	Y / N
	Joint pain: Yes / No	Y / N	Y / N	Y / N	Y / N
	Enlarged lymph node$^{\psi}$: Yes / No	Y / N	Y / N	Y / N	Y / N
	Number of Vit A doses received	0 /1 / 2 / NA	0 /1 / 2 / NA	0 /1 / 2 / NA	0 /1 / 2 / NA
Travel history	Travel history (within 21 days before rash onset): Y / N. If yes, district name:	Y/N; If yes, district: _____	Y/N; If yes, district: _____	Y/N; If yes, district: _____	Y/N; If yes, district: _____
Complications	Complications, if any: (a) Pneumonia/ (b) Diarrhea/(c) Ear Infection/ (d) Eye complication/ (e) Encephalitis (f) Other	a / b / c / d / e/ f	a / b / c / d / e/ f	a / b / c / d / e/ f	a / b / c / d / e/ f
Pregnant women details	Any pregnant women in the house: Y / N; if yes, mention name and EDD	Y / N; if yes, Name: EDD: _/_/_	Y / N; if yes, Name: EDD: _/_/_	Y / N; if yes, Name: EDD: _/_/_	Y / N; if yes, Name: EDD: _/_/_
Health seeking behaviour	Health seeking behaviour after rash onset: (a) Confined at home/ (b)Contacted health facility/ (c) Contacted health worker/ Influencer ^{x}	a / b / c	a / b / c	a / b / c	a / b / c
	Did they refer / report case to any facility (Y/N)? If Yes mention Address and Type	Y / N; if yes, Type G/P/I/Q/O Address:	Y / N; if yes, Type G/P/I/Q/O Address:	Y / N; if yes, Type G/P/I/Q/O Address:	Y / N; if yes, Type G/P/I/Q/O Address:
	Case notified by the health facility Y/N	Y / N	Y / N	Y / N	Y / N
Sample	Sample collected: Y/N, If Yes: Serum (S)/Throat(T)/Urine(U)/ Nasopharyngeal (NP) Date of sample collection:	Y / N; if yes, S/ T/ U/ NP __/__/__	Y / N; if yes, S/ T/ U/ NP __/__/__	Y / N; if yes, S/ T/ U/ NP __/__/__	Y / N; if yes, S/ T/ U/ NP __/__/__
Death	If there is suspected measles death*, mention date of death	Date: __/__/__	Date: __/__/__	Date: __/__/__	Date: __/__/__
Nutrition	If the case is below 5 years, whether the child is malnourished Y/N	Y/N	Y/N	Y/N	Y/N

Abbreviations: Y =Yes; N=No; U=Unknown; M=Measles containing vaccine; MR=Measles & Rubella containing vaccine; MMR=Measles, Mumps & Rubella containing vaccine; MMRV=Measles, Mumps, Rubella & Varicella containing vaccine

Type of HRA code: Migratory HRA: 1 = Slums with migration; 2 = Nomads; 3 - Brick kiln; 4 - Construction site; 5 - Other migratory high-risk areas; Non-Migratory HRA: 6A- Settled Slums (notified & non-notified) 6B-Areas under Vacant / temporarily vacant (More than 3 months) sub centres 6C Areas with Measles/Rubella

€ Health Facility: G- Government allopathic/ P- Private allopathic/ I - ISM practitioner/ Q - Quack/ O- Other

x Malnourished child to be referred to health facility for investigation and management

$^{\psi}$ Enlarged lymph node refers to post auricular, sub occipital and posterior cervical lymph node enlargement

* Suspected measles death: is death within 30 days of onset of rash without any obvious cause like trauma, snakebite, etc.

MR-OB004 outbreak summary report

The outbreak will be considered over after there have been no further epidemiologically linked cases for one month from the date of onset of rash of the last case documented on the VPD OB-003.		
Notification		
Source of notification (encircle): weekly report (NPSP/IDSP)/active case search/media/other		
If other, please specify:	Date of notification of index case:	
Index case reported by:	Designation:	
Name of DIO:	Name of SMO:	
Location of the outbreak		
Name of village/ward affected:	Total population of village:	
Name of subcenter:	Name of PHC/UHC:	Name of block:
District:	State:	
Cross notification needed (encircle): yes/no	Outbreak ID:	
Preliminary search including desk review		
Date of desk review:	Date/s of preliminary search:	
Total number of suspected measles cases in preliminary search:		
Number of areas searched:	Number of sub-centers/urban wards searched:	
Whether considered as an outbreak requiring detailed investigation (encircle): yes/no		
If no, encircle reason:	1. No clustering of cases	2. Vesicular rash
	3. Others (please specify):	
If yes, provide following details of outbreak investigation as mentioned below		
Date of epidemic response team meeting:		
Date of pre-investigation orientation meeting:		

Detailed investigation	
Date of pre-outbreak investigation orientation:	No. of health workers trained: ANM: ASHA: AWW:
Date of outbreak investigation: from _____ to _____	Number of teams conducting HTH searches:
Number of sub-centers/urban wards involved:	Number of villages/mohalla involved:
Date of rash onset of index case:	Date of rash onset of primary case from OB003:
Active case searches	
Total number of suspected measles cases identified through ACS:	
Total number of suspected deaths due to measles identified through ACS:	Vit A supplementation given as per guidelines: yes/no
Number of schools and Anganwadi screened during ACS searches:	
Number of temple sites/faith healers identified within OB area:	
Number of temple sites/faith healers sensitized within OB area:	
Number of ACS conducted in health facilities:	
Laboratory investigation details	
Details serum specimens collected	

Case number	Age	Sex	Date of last MRCV dose	Date of collection of specimens	Date sent to lab	Date received in lab	Result IgM positive (M/R) IgM negative (M/R) Mixed (for M+R)	Date of result
__ __ __								
__ __ __								
__ __ __								
__ __ __								
__ __ __								

Check box: Outbreak classification		
	☐ Measles OB (≥2 confirmed measles)	☐ Rubella OB (≥ 2 confirmed rubella)
	☐ Mixed OB (≥2 confirmed measles + ≥ 2 confirmed rubella)	☐ Discarded (< 2 confirmed cases)

2

Details of virology specimens: *T=Throat swab U=Urine N= Nasopharyngeal swab									
Case Number	Specimen type* (T/U/N)	Age	Sex	Date of last MRCV dose	Date of collection of specimens	Date sent to lab	Date received in lab	Measles virus type (_____) / Rubella virus type (_____) / Negative	Date of Result
— — —									
— — —									

Passive surveillance	
Number of health facilities reporting suspected cases through passive surveillance:	
Number of faith healers/temple sites reporting suspected cases through passive surveillance:	
RI intensification	
Additional session conducted: yes/no	If yes, date session conducted:
If no, please specify the reason:	
No. of unimmunized/under-immunized children <5 years of age identified and due-listed for age-appropriate vaccination:	
No. of unimmunized/under-immunized children <5 years of age vaccinated in additional session:	
Epidemiological characteristics (from OB003 and OB004)	
Duration of the outbreak:	Size of the outbreak (lab confirmed + epi-linked):
Number of lab confirmed cases:	Number of epi-linked cases:
Is the affected area high risk area (encircle): yes/no	If yes, type of HRA:
Sex proportion (lab confirmed + epi-linked) % male _____% female_____	Religion proportion (lab confirmed + epi-linked) % Hindu_____, % Muslim_____, % Others_____

Age group	Vaccination status (lab confirmed + epi-linked)				Total	Any remark/ observation:
	Zero dose	One MRCV dose	Two or more MRCV doses	Unknown dose		
< 9 months						
9 months < 1 yr.						
1 year ≤ 4 yrs.						
5 years ≤ 9 yrs.						
10 ≤ 14 yrs.						
≥15 yrs.						
Total						

Data analysis	
Spot map of cases in an outbreak area prepared	yes / no
Epi curve of cases in an outbreak area plotted	yes / no
$\text{Attack rate} = \frac{\text{Number of cases of measles/rubella}}{\text{Total population}} * 100$	
$\text{Age specific attack rate} = \frac{\text{Number of measles/rubella cases in age group}}{\text{Total population of the age group}} * 100$	
$\text{Case fatality rate (CFR)} = \frac{\text{Total number of deaths due to measles/rubella}}{\text{Total number of measles/rubella cases}} * 100$	

District Immunization Officer **Medical Officer-in Charge**

4

DPT - CIF

Vaccine Preventable Diseases
CASE INVESTIGATION FORM

EPID Number DTH / PTS / NNT - IND _____ _____ _____ _____
(Encircle syndrome) (matches Lab Request Form)

1. Reporting / Investigation Information:

Date Case Reported: ____/____/_____ Reported by: _____ Title: _____

Date Case Investigated:____/____/_____ Investigated by: _____ Title: DIO / DSO / Medical Officer / Nodal Officer / SMO / Other

Date Case verified: ____/____/_____ Verified by: _____ Title: SMO / DIO / DSO

Reporting Health Facility: **Type:** RU / Informer / Other / ACS (facility) / Community Search **Setup:** Govt. Allopathic / Pvt Allopathic / ISM Pract. / Others

2. Case Identification: Patient's Name: _____ other given names: _____

Sex: M/F/O Date of birth (DOB): ____/____/_____ [ ] precise DOB unknown (enter best estimate of age: years_____ months_____)

Father's Name:_____ Mother's Name:_____

Father's Occupation:_____ Grandfather's Name:_____

Address: _____ Religion: Hindu / Muslim / Other Caste: _____

Landmark: _____ Village / Mohalla: _____ HRA per microplan?: Y / N

Panchayat/Ward No.: _____ **Pin Code:** _____ **ID No:(** **)**_____

Block /Urban area: _____ District: _____ Setting: Urban / Rural

State: _____ Tel. _____ Alternate tel. _____

Child belongs to migratory family/Community : Yes/ No/ Unknown If yes, specify: Slum with migration/ Nomad/ Brick Kiln/ Construction site/ Others (specify): _____

3. Hospitalization: Yes / No Name of Hospital:_____

Date of Admission:____/____/_____ Date of Discharge/LAMA/Death:____/____/_____

4. Vaccination Status: Has the case ever received one or more vaccines (of any listed below) in his or her lifetime? Yes / No / Unknown

If vaccinated, encircle vaccines received irrespective of age when they were received

At birth	6 weeks	10 weeks	14 weeks	9 months	16 months	5 years	Others
OPV 0	OPV 1	OPV 2	OPV 3	M1 / MR1 /	M2 / MR2 /	DPT Booster	Td 10
BCG	DPT 1	DPT 2	DPT 3	MMR1 / MMR	MMR2 / MMRV2		Td 16
HepB 0	Pentavalent 1	Pentavalent 2	Pentavalent 3	JE 1	DPT Booster		Tdap
	HepB 1	Hep B 2	HepB 3	PCV Booster	OPV Booster		TT
	f-IPV 1		f-IPV 2 / IM-IPV	f-IPV 3	JE 2		HPV
	PCV 1		PCV 2				
	Rotavirus 1	Rotavirus 2	Rotavirus 3				

Source of vaccination status: RI Card / Any Record or Register / Recall / Both recall and register / Other, Specify (if Others)_____

Date of last dose of diphtheria or pertussis-containing vaccine: **For diphtheria** (DPT,Pentavalent, Td or Tdap); **For pertussis** (DPT, Pentavalent, Tdap) ____/____/_____

In case of NNT - Vaccination of mother during pregnancy: Tetanus Toxoid (TT/Td): 0 / 1 / 2 / Booster / Unknown Date of last dose of TT/Td:____/____/_____

5. Clinical Symptoms: Duration of illness in days: _____

Date of Onset:____/____/_____	**Diphtheria:**	**Pertussis:**	**Neonatal Tetanus:**
	Sore Throat: Yes / No	Duration of cough:	Child sucked and cried normally at 0-2 days: Yes / No
	Fever: Yes / No	Cough >2 weeks:Yes / No	Onset of following symptom(s) at 3-28 days of age:
Diphtheria*:	Greyish white adherent	Paroxysms of cough: Yes / No	Inability to suck and cry: Yes / No
Date of onset of sore throat	membrane in throat: Yes / No	Cough leading to vomiting:	Stiffness: Yes / No
Pertussis*:	Bloody nasal discharge: Yes / No	Yes / No	Spasms / Seizures: Yes / No
Date of onset of cough	Hoarseness of voice: Yes / No	Whoop: Yes / No	If yes, precipitated by stimuli: Yes / No
Neonatal Tetanus*:	Bull neck: Yes / No	Apnoea: Yes / No	Delivery: Institutional / Home / Other (Specify: _____)
Date of onset of inability to suck	Nasal regurgitation: Yes / No	Cyanosis: Yes / No	If home delivery, birth attended by:
	Difficulty in swallowing: Yes / No	History of active TB / other	Medical doctor / Nurse / ANM / Other (Specify: _____)
	Difficulty in breathing: Yes / No	chronic URTI: Yes / No	Any substance applied on cord: None / Medicine / Other
		Clinician suspicion of pertussis: Yes / No	If other substance, specify: _____

*Diphtheria: An illness of upper respiratory tract characterized by the following:• laryngitis or nasopharyngitis or pharyngitis or tonsillitis AND • adherent membranes of tonsils, pharynx and/or nose

*Pertussis: A person with an acute cough lasting ≥ two weeks or of any duration in an infant with at least one of the following:• paroxysms (i.e. fits) of coughing • inspiratory whooping • post-tussive vomiting or vomiting without apparent cause • Apnoea (only in <1 year of age) OR Clinician suspicion of pertussis

*Neonatal tetanus: Any neonate with a normal ability to suck and cry during the first two days of life, and who between 3 and 28 days of age cannot suck normally,and becomes stiff or has convulsions/spasms (i.e. jerking of the muscles) or both OR any neonate who died of unknown cause during the first month of life

CIF contains two pages, both pages must be filled for all suspected VPD cases

Identification Number Code: 1 - Aadhaar card, 2 - Voter Card, 3. PAN, 4. Passport, 5. Driving licence number, 6. National Health ID, 7. State Health ID, 8. Other

CIF (Page 2) **EPID No.:** DTH / PTS / NNT - IND - ____ - _____ - _____ - _____

6. Treatment History: Antibiotic given: Yes /No / Unknown if Yes: Antibiotic started before specimen collection: Yes / No / Unknown

(Ask if it is possible to see medication to confirm antibiotic type from label) ------> If antibiotic given, indicate which: Penicillin/Azithromycin/Erythromycin/Cotrimoxazole/Clarithromycin/Tetracycline/Doxycycline/ Amoxicillin/Ampicillin/Augmentin/Cefixime/Unknown type/Other:Specify_____

Diphtheria Antitoxin (DAT): Y / N / Unknown / Not Applicable (not a diphtheria case) Dose of DAT: _____IU

Reason for not giving antitoxin: DAT not available / Other _____

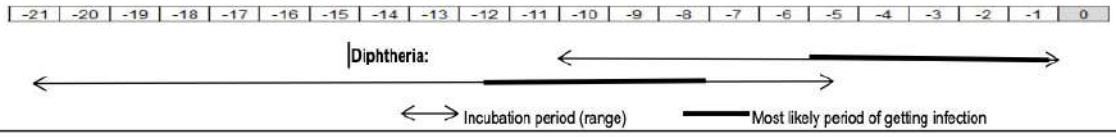
7. Contact History:

History of contact with a laboratory confirmed case: Y / N If yes, EPID No of laboratory confirmed case: _____

Similar symptoms in other household contact(s): Y / N If yes, No. of sick contacts: _____ details: _____

Similar symptoms in other neighbourhood/ work/ school contact(s): Y / N If yes, No. of sick contacts: _____ details: _____

8. Travel History: Travel of suspected case prior to onset (indicate dates and place of travel with arrows on date line)



Requires cross notification? Yes / No

If yes, date of cross notification: ____/____/_____

District of residence: _____

(In case of Neonatal Tetanus, district of delivery)

Block/ Urban area of residence: _____

(In case of Neonatal Tetanus, block of delivery)

9. History of contacts with healthcare providers after the date of onset (including reporting health facility):

Name & address of Hospital/ doctor:	1	2	3	4
Phone no. / Email ID				
Dates case visited:				
Already RU/informer?	Yes/No	Yes/No	Yes/No	Yes/No
Did they report this case?	Yes/No	Yes/No	Yes/No	Yes/No
Date of sensitization visit/ Actions taken to improve case reporting				

10. Specimen Collection:

	Number	**Date Collected**	**Time Collected**	**Date Sent**	**Name of Lab**	**Date of Result**	**Condition**	**Laboratory Result**
Throat swab (Diphtheria)	_____	__/__/__	__:__	__/__/__	_____	__/__/__	Good / Poor	Positive / Negative / Other
Nasopharyngeal swab (Pertussis)	_____	__/__/__	__:__	__/__/__	_____	__/__/__	Good / Poor	Positive / Negative / Other
Serum (Pertussis)	_____	__/__/__	__:__	__/__/__	_____	__/__/__	Good / Poor	Positive / Negative / Intermediate

If no specimen is collected, reason for not collecting specimen: Death / Not willing / Lost to follow-up / Logistic issue / Late notification / Other

If other, specify: _____

11. Name of Govt Health Facility responsible for Active Case Search, Contact Tracing and Response in Community: _____

_____ Active case search in community done: Yes / No

If yes, Date of search: ____/____/_____ Number of individuals verified: _____ Number of suspected cases found: _____

Number of contacts identified: _____ Number of contacts received antibiotics:_____ Number of susceptibles vaccinated:_____

12. Final Classification: Laboratory confirmed / Epi-linked / Clinically compatible / Rejected / Confirmed NNT

13. 60 Day follow-up (telephonic) Date of follow-up: __/__/__ Outcome: Alive / Lost / Death (Death date: ____/ ___/ _____)

14. Complications: At anytime during illness or follow up:

Complications of Diphtheria: Myocarditis / Paralysis (palatal,pharyngeal,facial,oculomotor, limb) / Peripheral neuropathy / Pneumonia / Otitis media / Respiratory insufficiency / Other

Complications of Pertussis: Pneumonia / Seizures / Encephalopathy / Otitis media / Pressure effects (pneumothorax,epistaxis,subdural hematomas,hernias,rectal prolapse) / Other

Complications of Neonatal Tetanus: Residual weakness / Delayed milestones /Other _____

Use extra sheet of paper to write additional information, if any.

DPT Surveillance

LABORATORY REQUEST FORM

(To refer specimens to the laboratories)

EPID Number:

DTH / PTS - IND - _ _ - _ _ _ - _ _ - _ _ _

(matches VPD Case Investigation Form)

PART I : Case details to refer specimens :

Case Information :

Patient's name : _____ Father's name : _____

Sex : _____ Date of birth : _____/_____/_____ Age : years_____ months_____

Address : _____ Village/City: _____

District : _____ State : _____

Date of onset : _____/_____/_____ (Diphtheria: Sore throat; Pertussis: Cough)

Specimen collection :	**Type of specimen**	Number	**Date specimen collected**	**Date specimen sent**
	Throat swab	_____	_____/_____/_____	_____/_____/_____
	Nasopharyngeal swab	_____	_____/_____/_____	_____/_____/_____
	Serum		_____/_____/_____	_____/_____/_____

Name of the laboratory: _____

Name of person sending the specimen : _____ Designation : _____

Email id: _____ Mobile / WhatsApp Number: _____

Address : _____

PART II: Receiving at Laboratory :

Type of specimen	**Date specimen received**	**Condition of specimen**	**If poor specify**
Throat swab	_____/_____/_____	Good / Poor	_____
Throat swab	_____/_____/_____	Good / Poor	_____
Nasopharyngeal swab	_____/_____/_____	Good / Poor	_____
Nasopharyngeal swab	_____/_____/_____	Good / Poor	_____
Serum	_____/_____/_____	Good / Poor	_____

Signature : _____ Lab Stamp:

Active Case Search (ACS) and Public Health Response for Suspected Diphtheria and Pertussis Case

State _____ District_____ PHC/Planning Unit_____

Village/Area_____ Team Members_____ Date of visit _____/_____/_____

1	Serial number of household																		
2	Name of head of the family																		
3	Religion (H/M/O)																		
4	Total members in family (all age)																		
5	Number of suspected cases found (provide details below)																		
6	Age of youngest child in family (<15 yr) (Yr/Mon)	____/____			____/____			____/____			____/____			____/____			____/____		
7	No. of pentavalent / DPT doses to youngest child	0 / 1 / 2 / 3 / 4/ 5 / U			0 / 1 / 2 / 3 / 4/ 5 / U			0 / 1 / 2 / 3 / 4/ 5 / U			0 / 1 / 2 / 3 / 4/ 5 / U			0 / 1 / 2 / 3 / 4/ 5 / U			0 / 1 / 2 / 3 / 4/ 5 / U		
8	No. of members are close contact with index or suspected case	<1 yr	1-7 yr	>7 yr	<1 yr	1-7 yr	>7 yr	<1 yr	1-7 yr	>7 yr	<1 yr	1-7 yr	>7 yr	<1 yr	1-7 yr	>7 yr	<1 yr	1-7 yr	>7 yr
9	No. of close contacts received antibiotics																		
10	No. of close contacts and/or un-and under immunized in family																		
11	No. of members received vaccine																		

Details of suspected cases:

Sl. No.	House No.	Patient's name & Address	Phone Number	Name of school/ work place	Sex	Age (Yrs/Mnths)	Hospitalization (Y/N)	Diphtheria: Sore throat	Pertussis: Cough of >2 weeks
1					M / F	___ / ___	Y / N	Y / N	Y / N
2					M / F	___ / ___	Y / N	Y / N	Y / N
3					M / F	___ / ___	Y / N	Y / N	Y / N
4					M / F	___ / ___	Y / N	Y / N	Y / N
5					M / F	___ / ___	Y / N	Y / N	Y / N

Diphtheria: Vaccination - A single dose of age appropriate vaccine for close contacts, left outs, drop outs and persons who have not taken DPT containing vaccine in last 5 years. Antibiotics prophylaxis- Close contacts are household contacts, people with direct contact (e.g. caretakers, relatives, sexual contacts, friends who regularly visit the home, students), health care worker

Pertussis: Vaccination - A single dose of Penta/DPT to children who are left out or drop out; Antibiotic prophylaxis – To infants and close contacts (family contact, overnight stay in same room, direct contact with a lab confirmed case)

VPD-ACS_NNT **Rapid Community Survey for Neonatal Tetanus Case and Response**

State _____ District _____

PHC/Planning Unit _____ Village/Area _____

Team Members: _____ Date of visit: ____/____/____

1	Serial number of households										
2	Name of head of the family										
3	Religion (H / M / O)										
4	Caste										
5	Name of mother who has delivered in last 2 years										
6	No. of TTCV doses received during last pregnancy (protected if 2 doses received)	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown	0/ 1 / 2/ unknown
7	No. of TTCV doses received in all pregnancies (protected if 3 or more doses received)	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown	0/ 1/ 2/ 3/ >3/ unknown
8	Place of delivery (home / hospital / other-specify)										
9	If home delivery, birth attended by (doctor, nurse, ANM, Dai / TBA, relative, other-specify)										
10	Any substance applied on cord	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
11	If yes, write the name of substance (none, medicine, oil, other-specify)										
12	Date of birth of last-born child										
13	Survival status of the last-born child	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead	Alive / Dead
14	No. of doses of Pentavalent vaccine received by the child	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown	0/ 1/ 2/ 3/ unknown

Summary: No. of mothers received 2 doses during last pregnancy or 3 or more doses during all pregnancies_____; No. of mothers vaccinated with TTCV following community survey_____
No. of mothers delivered at hospital_____; No. of mothers did not apply any substance on cord_____
No. of children who were eligible for Penta 3 vaccine_____
No. of eligible children had not received Penta 3 vaccine_____; No. of children vaccinated for their missed doses following community survey_____

[**Process of conducting the community survey:** Starting from the house where the confirmed NNT case occurred, move house-to-house to interview 10–15 other mothers in the community **who delivered in the last two years** about their vaccination status, delivery place and attendant, application of substances to the umbilical cord, and the survival and vaccination status of their last-born child.]

DPT and MR Surveillance Case and Sample Tracking Register

Case reporting and investigation details												Sample Tracking Information							
S. No.	Date of notification (DD/MM/YY	Name of Notifying health facility with Type (RS/Non RS)	Type of Suspected Disease (MR - Measles Rubella, 'DTH' - Diphtheria / 'PTS' for Pertussis / 'NNT' for Neonatal Tetanus)	Name of suspected case	Age & Sex	Father's name and Address (along with landmark and contact number)	Date of Investigation	Name & Designation of Investigator	Whether the case meets the criteria of the disease notified (Yes / NO)	If yes mention EPID no / otherwise mention Rejected	Date of Onset	Sample collected (Throat swab / Nasopharyngeal swab / Serum / Urine)	Date of sample collection	Date Sample received at District office	Date of sending sample to lab	Date of community ACS done	No of additional VPD cases found during ACS along with their EPID no.	If this case is part of an outbreak, mention Outbreak ID ID	Remarks (mention - Cross notification details, reasons for delay in investigation / sampling , reason for not collecting sample, reason for not conducting ACS)

Typhoid - CIF

Typhoid Fever Surveillance
CASE INVESTIGATION FORM

EPID Number: TYF - IND ____ _____ _____ _____
(matches Lab Request Form)

1. Reporting / Investigation Information:

Date Case Reported: ____/____/_____ Reported by: _____ Title: _____

Date Case Investigated:____/____/_____ Investigated by: _____ Title: DIO / DSO / MO / Nodal Officer / SMO / Other

Date of Desk Review: ____/____/_____ Reviewed by: _____ Title: SMO / DIO / DSO

Reporting Health Facility Setup: **Govt. Allopathic / Pvt Allopathic / ISM Pract. / Others**

2. Case Identification: Patient's Name: _____ other given names: _____

Sex: M/F/O Date of birth (DOB): ____/____/_____ Age: years_____ months_____

Father's Name:_____ Mother's Name:_____

Father's Occupation:_____ Grandfather's Name:_____

Address: _____ Religion: Hindu / Muslim / Other Caste: _____

Panchayat/Ward No: _____ **Pin Code:** _____ **ID No:( )**_____

Landmark: _____ Village / Mohalla: _____

Block /Urban area: _____ District: _____ Setting: Urban / Rural

State: _____ Tel. _____ Alternate tel. _____

Child belongs to migratory family/Community : Yes/ No/ Unknown

If yes, specify: Slum / Nomad/ Brick Kiln/ Construction site/ Others (specify)_____

3. Hospitalization: Yes / No Name of Hospital:_____

Date of Admission:____/____/_____ Date of Discharge/LAMA/Death:____/____/_____

4. Vaccination Status:

Source of vaccination status: RI Card / Any Record or Register / Recall / Both RI card and recall

No. of doses of pentavalent vaccine received: _____ No. of doses of PCV received:_____ No. of doses of M/MR/MMR vaccine received: ____

No. of doses of typhoid vaccine received: _____ Date of 1st dose of typhoid vaccine___/___/___ Date of 2nd dose of typhoid vaccine___/___/___

5. Clinical Symptoms: Duration of illness in days: _____

Date of Onset of fever:____/____/_____ Fever for at least three out of seven consecutive days: Yes / No / Unknown

Maculo-papular Rash: Yes / No Malaise: Yes / No Headache: Yes / No

Abdominal discomfort: Yes / No Diarrhoea: Yes / No Constipation: Yes / No

Complication: Intestinal hemorrhage / intestinal perforation / encephalopathy/ hemodynamic shock/ others_____

On examination/investigation: Liver enlarged: Yes / No / not palpated Spleen enlarged: Yes / No / Not palpated Pulse per minute:____

WASH practices:

Source of drinking water supply: Piped water in home / public tap / water tanker / hand pump or bore-well/ other sources (specify) _____

Toilet in the house: Yes / No **Handwashing practice**: Use of soap after defecation: All members / Few members / None of the members

Identification Number Code: 1 - Aadhaar card, 2 - Voter Card, 3. PAN, 4. Passport, 5. Driving licence number, 6. National Health ID, 7. State Health ID, 8. Other

CIF contains two pages, both pages must be filled for all suspected Typhoid fever cases

CIF (Page 2) **EPID No.:** TYF - IND - ___ - _____ - _____ - _____

6. Treatment History: Antibiotic started before specimen collection: Yes / No / Unknown

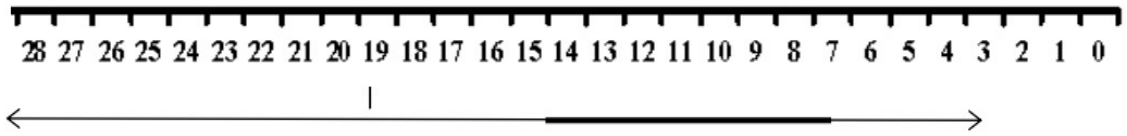
medication to confirm antibiotic type from label) ----- If antibiotic given, indicate which: Ceftriaxone/Cefotaxime/Cefixime/Azithromycin/Cotrimoxazole/Ciprofloxacin/Ofloxacin/ Amoxicillin/Ampicillin/Coamoxiclav/Aztreonam/Unknown type/Other:Specify_____

7. Contact History:

Similar symptoms in other household contact(s): Y / N If yes, No. of sick contacts: ____

Similar symptoms in neighbourhood / school contact(s): Y / N If yes, No. of sick contacts: ____

8. Travel History: Travel of suspected case prior to onset (indicate dates and place of travel with arrows on date line)



District of residence: _____

Requires cross notification? Yes / No

Block/ Urban area of residence: _____

If yes, date of cross notification: ___/____/____

9. Specimen Collection:

	Amount	Date Collected	Date Sent	Name of Lab	Condition	Date of Result	Laboratory Result
Blood culture		__/__/__	__/__/__		Good / Poor	__/__/__	Typhoid / Paratyphoid A / B / C / Negative / Other _____ _____

If no specimen collected, reason for not collection of specimen: Death / Not willing / Lost to follow-up / Logistic issue / Late notification / Other

If other, specify: _____

10. Active Case Search and Response in Community:

If yes, Date of search: ____/____/_____ Number of households verified: _____ Number of suspected cases found: _____

Water source tested for: typhoid / coliform / Not tested / Not known If yes, findings: typhoid positive / coliform positive / Both negative

11. Final Classification: Laboratory confirmed typhoid / paratyphoid A or B or C / Suspected case / Rejected / invasive Nontyphoidal Salmonella

12. 60 Day follow-up (telephonic)

Date of follow-up: ____ /____/_____ Outcome: Alive / Lost / Death (if died, date of death: ___/ __/ ____)

If alive, any complication/s: _____

Case definition of suspected typhoid fever: A patient between >6 months to <15 years of age presenting to the hospital outpatient/inpatient department (including emergency department) with

- a self-reported history of fever for ≥72 hours within the last 7 days,
- with the absence of the following signs or symptoms: coryza / rhinorrhea with presumptive diagnosis of upper respiratory tract infection and vesicular exanthem.

Blood culture (Aerobic Pediatric bottle):

Patient age	Blood volume
<2 year:	1-2 ml
2 - <5 year:	2-3 ml
5 - <15 year:	5-10 ml

Use extra sheet of paper to write additional information, if any.

Lab Request Form - Typhoid

Typhoid Surveillance
LABORATORY REQUEST FORM
(To refer blood specimen to the laboratory)

EPID Number:
TYF - IND - _ _ - _ _ _ - _ _ - _ _ _
(Match with Case Investigation Form)

PART I: Case details to refer specimen:

Case Information:

Patient's Name: _____ **Father's Name:** _____

Sex: _____ **Date of birth:** ____ / ____ / _____ **Age: years**_____ **months** _____

Address: _____ **Village/City:** _____

District: _____ **State:** _____

Date of onset of fever: ____ / ____ / _____

Blood culture sample:	**Amount of blood**	**Date specimen collected**	**Date specimen sent**
	____ml	____ / ____ / _____	____ / ____ / _____

Name of Laboratory: _____

Name & designation of person sending the specimen: _____

Email id: _____ **Mobile / WhatsApp number:** _____

Address: _____

_____

PART II: Receiving at Laboratory:

Type of specimen	**Lab ID**	**Date specimen received**	**Condition of specimen**	**If poor, specify**
Blood*	_____	___ /___ /_____	**Good / Poor**	_____

Name of receiving laboratory:

Name & signature of person received the specimen:

***Blood after collection should be immediately inoculated in blood culture bottle which should be transported to the laboratory in an ambient temperature protected from extreme variations in temperature within four hours.**

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