GAVI Alliance

Annual Progress Report 2011

Submitted by

The Government of

India

Reporting on year: **2011**
Requesting for support year: **2013**
Date of submission: **5/23/2012**

Deadline for submission: 5/22/2012

Please submit the APR 2011 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2011**

Requesting for support year: **2013**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2012

1.2. Programme extension

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2013	2014

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2011	Request for Approval of
ISS	No	ISS reward for 2011 achievement: N/A
HSS	No	next tranche of HSS Grant N/A
CSO Type A	No	Not applicable N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 is available here.

2. Signatures

2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of India hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of India

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Ms. Anuradha Gupta	**Name**	Dr. Sheela Prasad
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr Pradeep Haldar	Deputy Commissioner (Immunization), Immunization Division, MOHFW, New Delhi, India	+91-11-23062126	pradeephaldar@yahoo.co.in

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date
Mr. Billy Stewart/ Senior Health Advisor	DFID		
Dr Henry Van den Homberg / Chief of Health	UNICEF		

Dr Nata Menabde/ WHO Representative	World Health Organization		
Dr Vikram Rajan / Public Health Specialist	World Bank		
Ms. Kerry Pelzman	USAID		
Dr Rajshankar Ghosh /Technical Director	PATH		

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

India is not reporting on Health Systems Strengthening (HSS) fund utilisation in 2012

2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

India is not reporting on CSO (Type A & B) fund utilisation in 2012

3. Table of Contents

This APR reports on India's activities between January – December 2011 and specifies the requests for the period of January – December 2013

Sections

4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)					
	2011		2012		2013		2014	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	1,590,000	1,673,000	1,600,000	2,546,000		5,189,000		5,239,000
Total infants' deaths	40,000	40,000	40,000	78,250		199,000		202,000
Total surviving infants	1550000	1,633,000	1,560,000	2,467,750		4,990,000		5,037,000
Total pregnant women	1,749,000	1,840,300	1,760,000	2,801,250		5,707,000		5,762,000
Number of infants vaccinated (to be vaccinated) with BCG	1,550,000	1,937,392	1,560,000	2,546,000	0	5,189,000	0	5,239,000
BCG coverage	97 %	116 %	98 %	100 %	0 %	100 %	0 %	100 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,550,000	1,996,876	1,560,000	2,467,750		4,990,000		5,037,000
OPV3 coverage	100 %	122 %	100 %	100 %	0 %	100 %	0 %	100 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,550,000	2,023,374	1,560,000	2,467,750	0	4,990,000	0	5,037,000
Number of infants vaccinated (to be vaccinated) with DTP3	1,550,000	1,993,224	1,560,000	2,467,750		4,990,000		5,037,000
DTP3 coverage	100 %	122 %	100 %	100 %	0 %	100 %	0 %	100 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	25	0	25	0	4,990,000	0	5,037,000
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.33	1.00	1.33	1.00	0.00	1.00	0.00
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	1,550,000	74,112	1,560,000	2,467,750	0	4,990,000	0	5,037,000
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	1,550,000	0	1,560,000	2,467,750		4,990,000		5,037,000
DTP-HepB-Hib coverage	100 %	0 %	100 %	100 %	0 %	100 %	0 %	100 %
Wastage[1] rate in base-year and planned thereafter (%)	25	25	25	25	0	25	0	25
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.33	1.33	1.33	1	1.33	1	1.33
Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,550,000	1,949,310	1,560,000	2,467,750	0	4,990,000	0	5,037,000
Measles coverage	100 %	119 %	100 %	100 %	0 %	100 %	0 %	100 %
Pregnant women vaccinated with TT+	1,749,000	2,062,493	1,760,000	2,801,250	0	5,707,000	0	5,762,000
TT+ coverage	100 %	112 %	100 %	100 %	0 %	100 %	0 %	100 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	N/A	0	N/A	0	N/A	0	N/A	0

Number	Achievements as per JRF		Targets (preferred presentation)					
	2011		2012		2013		2014	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	1 %	0 %	0 %		0 %		0 %

*

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [(A B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011.** The numbers for 2012 - 2012 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**
  - The year 2011 estimates, as submitted in APR 2010, reported the birth cohort for the entire year, However, the pentavalent vaccination in the proposed 2 states of India could be started in Dec 2011 only. Therefore, the coverage for pentavalent vaccine is reported for the period till 31st Dec 2011. The pentavalent vaccine was introduced for the new birth cohort, those attending immunization session for the first dose of DPT only. Therefore, no 3rd dose of pentavalent vaccine was administered till Dec 2011.
  - All immunization related data in India is reported through Health Management Information System (HMIS). This system is maturing, and there are still a few issues related to the reported coverage in this system. The actual number of doses administered for the majority of the antigens is coming to be more than the birth cohort. This is a system reported provisional data, which might be corrected by the states, at a later date.
  - The target beneficiaries for 2012 and 2013 have been revised as while pentavalent vaccination would continue in the 2 states, which started vaccination in 2011. The Government of India, now, proposes to introduce pentavalent vaccination in 6 additional states of the country, starting October 2012. Therefore, the estimates for 2012 includes the annual birth cohort for 2 states and 25% of the annual birth cohort for additional 6 states (October 2012 to Dec 2012). For the year 2013 and 14, the annual birth cohort of all 8 states has been reported.
- Justification for any changes in **surviving infants**

  As described above.
- Justification for any changes in **targets by vaccine**

  As described above
- Justification for any changes in **wastage by vaccine**

  Not applicable.

5.2. Immunisation achievements in 2011

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2011 and how these were addressed:

General Remark:
The GAVI Alliance new vaccine introduction support to the Govt. of India has been agreed to be in the form of commodity assistance (providing vaccine only). The cost of AD syringes, Hub cutters & other injection safety & waste disposal material, and the cost of service delivery of immunization program in <?xml:namespace prefix = st1 />India is borne by the Government of India. As per the GoI discussions with the GAVI Alliance, this cost is considered the GoI's contribution for the new vaccine introduction. However, the web based APR submission format has pre-designed co-financing calculations, which simultaneously calculate co-financing requirements. The online tool does not allow country to make any modification; therefore, the co-financing component should not be taken into the consideration while reading this APR.

Major Activities conducted and challenges faced in Immunization:

The Government of India has been fully supporting the Routine immunization programme in the country with own resources through National Rural Health Mission (NRHM) of India. The NRHM was launched in the year 2005 with a goal to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. The Mission envisages providing effective healthcare to rural population throughout the country by raising the outlays for Public Health from 0.9% of GDP to 2-3% of GDP. This has already reached to 1.2% of GDP in the year 2009. One of the main objectives of NRHM is the reduction in child and maternal mortality. The NRHM aims to improve resources, management capacity, accountability and state autonomy through decentralization of funds to the states. States are required to develop project implementation plans (PIPs) and funds are released to the states based on their approved plans. The efforts under the NRHM to date have shown an impact on Health system strengthening and on improving Immunization program service delivery.

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Progress in the ongoing activities:

- **The Govt of India has been conducting regular review meetings with the states to strengthen RI in India,**
- **National Vaccine Policy of India has been released in 2011,**
- **In recent years, ministry has initiated multiple steps under NRHM to strengthen RI service delivery and quality of immunization:**
- **Intensified efforts for decentralized planning**
- **Social mobilization**
- **Training of all cadre of immunization staff**
- **Strengthening immunization HMIS, Supportive Supervision and monitoring**
- **Accelerated disease control**
- **AEFI & VPD surveillance strengthening**
- **Strengthening program management capacity**
- **Introduction & scaling up of under-utilized and new vaccines**
- **Strengthening Cold Chain system and vaccine logistics management**
- **Improving injection safety including safe disposal of immunization waste**

Improving Service Delivery

- **The GoI taken major decision in 2011 and the Multi Dose Vial Policy (MDVP) for HepB Birth dose and OPV zero dose has been introduced in the entire country in 2011. Moreover, the MDVP has also been introduced for Pentavalent vaccine in 2 states of India,**
- **Decentralized planning and need based funding through NRHM and state Project Implementation Plans (PIPs),**
- **Cold chain strengthening through expansion and replacement of CFC equipment,**
- **Provision of alternate vaccine delivery mechanism and provision of alternate vaccinator for under-served urban and rural areas,**
- **Provision of 2nd ANM at Sub centers in difficult to access areas and in the poor performing states,**
- **Improving mobilization for immunization and improved tracking to reduce drop outs through Accredited Social Health Activist (ASHA) hired at village level (>800,000 hired Source: NRHM),**
- **Increasing institutional deliveries through cash incentive based scheme Janani Suraksha Yojana (JSY).**

Training of Health Workers in immunization

Since 2007-08, over 225,000 out of total 250,000 Health Workers which included ANMs, MPW(M), LHV, HA(M), Data handlers and other immunization related field staff have been trained by the end of year 2011.

- The immunization handbooks and facilitators guides had been revised in 2011 **to incorporate the recent initiatives under NRHM in Immunization program and also the feedback received on previous version of the handbook. More than 100,000 copies of these handbooks and 3,000 copies of facilitator's guides have been printed and widely disseminated to all the states for conducting further trainings and refresher trainings.**

- **The Immunization Handbooks for health workers have been translated into the local language by the states and are extensively being utilized for the trainings by the states.**

Trainings of Medical Officers in immunization:

- **Immunization Handbook for Medical officer's training developed in 2008. The trainings using this module had started in India since 2008 and till now, about 1,600 trainers trained in the country and 29,000 out of 62,000 Medical officers trained in different states as of Dec 2011.**

- **A second revised and updated version of these handbooks had been printed and now being utilised in the country.**

- **The statndardized training kits have been designed and being used in India for conducting the trainings of the MOs in the country.**

Cold Chain handlers training in Immunization:

- **National cold chain training centre located at SHTO, Pune has been revived in 2007.**
- **Since 2007 till end 2011, this center has trained 457 officials on non CFC ILR/DF repair and maintenance and 154 technicians on WIC/WIF repair, maintenance and 98 officials from 16 states on solar cold chain equipment installation, repair and maintenance. The TOTs for repair of voltage stabilizers conducted on 2009 and 29 trainers trained who in turn are training the cold chain technicians in their respective states. By the end of Dec 2011, almost all 460 cold chain technicians have been trained.**
- **National training module along with facilitator guide was developed in the year April 2010 and 221 state trainers are trained in 9 TOTs (2010-11). All states covered except Lakshadweep and Dadra & Nagar Haveli. Trainings had started in Andhra Pradesh, Gujarat, Goa, Karnataka, UP, Mizoram, Orissa, Delhi, Arunachal Pradesh, Maharashtra in 2010 and approx 17% (5,428/32,800) of cold chain handlers are trained using this training module till 201. The cold chain handlers trainings also continued in 2011 in India.**
- **The National Cold Chain MIS developed by National Cold chain training centre, Pune in 2011.**

Monitoring of Routine Immunization Program in India:

- **The RI monitoring formats have been revised and widely disseminated amongst the states. The intensified monitoring efforts are ongoing in Bihar, Uttar Pradesh, Jharkhand, and a few other states. The trainings in RI monitoring has been conducted in a number of new states and states plans to role out the RI monitoring. Punjab, Maharashtra and West Bengal states have also started reporting on the RI monitoring data.**

Adverse Events Following Immunization Surveillance in India:

- **There is a thrust on strengthening AEFI reporting system in the country. There has been increasing trends in the reporting of serious AEFI cases in India. In the year 2011, a total of 300 serious AEFI cases were reported from 132 districts of 24 states of the country.**

- **National AEFI committee constituted in January 2008. AEFI committees have been constituted in all 35 States. Till the end of 2011, total 13 states have conducted State level AEFI workshops (for sensitization of District AEFI committee members and Immunization Program Managers). In 2011, Assam, Uttarakhand and Uttar Pradesh states conducted state level workshops in 2011.**

- **India joined the WHO Global Network of Post Marketing Surveillance (PMS) with Maharashtra state of India being a participating state. The initial trainings in the software tool for data entry was conducted in the**

month of August 2010 and a subsequent training was conducted in Sept 2011.

- **The AEFI surveillance and response operational guidelines were revised in 2010. A total of 25,000 copies of these guidelines have been printed and widely disseminated, to be distributed to all members of State and district AEFI committees and for health facilities up to Primary Health center level in India.**
- **In 2011, an abridged version of National AEFI standard operating procedures were prepared and printed. 40,000 copies of these guidelines had been printed and disseminated amongst medical officers across the country.**
- **As part of the Measles SIAs preparation, the trainings of district and state level officials have been conducted in AEFI surveillance and reporting on all measles SIA districts.**
- **National AEFI committee met 4 times in 2011 and reviewed various surveillance aspects.**
- **The National level causality assessment working group conducted the causality assessment of 72 cases available in the national database in July 2011. A causality assessment training of experts on AEFI causality assessment was conducted in Maharashtra state in November 2011.**

New vaccine introduction:

Accelerated measles control:

India has the started the measles 2nd dose for all children in the country. 21 states which has MCV1 coverage more than 80%, have introduced the measles second dose in UIP along with 1st DPT booster. 14 states, which have MCV1 coverage of <80% have started measles Supplementary immunization activities, followed by the introduction of MCV2 in UIP. In November 2010, Government of India initiated measles catch–up campaigns in 14 high burden states. In total, 134 million children age 9 months to 10 years old in 361 districts are targeted for vaccination in a phased approach. Phase 1 of the campaign was conducted in 45 districts and vaccinated 11.2 million children. Till Dec 2011, when the phase II of Measles SIAs was underway in 157 districts, and approximately 27 million of the targetted 42 million children had been vaccinated. Following activities have been done for Measles SIAs in India with partner support:

- **Development and printing of National Operational Guidelines for measles SIAs in India**
- **Training of state and district-level trainers in measles SIA districts**
- **Establishment of adverse events following immunization (AEFI) management networks and training of district and block medical officers (> 4,000 medical officers trained).**

Along with the scale-up of measles catch-up campaigns, with the technical support from WHO/NPSP and in collaboration with the Integrated Disease Surveillance Project (IDSP) to expand laboratory supported measles surveillance. Lab supported measles outbreak surveillance has been established based on the existing AFP surveillance reporting network and is presently operational in 11 states (Assam, Andhra Pradesh, Bihar, Gujarat, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Rajasthan, Tamil Nadu and West Bengal).

Introduction of Japanese Encephalitis (JE) vaccination:
A multi-year (2006-10) plan for implementation of phased JE campaigns in districts is being followed. All 112 endemic districts in 15 states have conducted JE vaccination campaign followed by the introduction of vaccine in RI.

Hepatitis B Vaccine introduction:

HepB vaccination program in India had started in phased manner, with GAVI support in 2002. It was expanded to 10 states in 2007/08. The GAVI support for Hepatitis B vaccine ended in Dec 2009. Starting since January 2010, The Govt. of India had taken over the procurement of the vaccine from internal funds for all these 10 states. Starting 2011, the Hepatitis B vaccination program has been scaled up to the entire country with its own funds.

Introduction of Hib as Pentavalent vaccine:
The National Technical Advisory Group on Immunization (NTAGI) recommended the introduction of Hib as Pentavalent vaccine (DPT-HepB-Hib) in the country in 2008. GoI has introduced the HIb as Pentavalent vaccine in in 2 states namely Tamil Nadu and Kerala in 2011. The Govt. of India has plan to further expand pentavalent vaccine introduction in additional 6 states of the country in 2012.

Collaboration with Partner Agencies:

- **GoI is working in close collaboration with technical and funding partners in the field of immunization such as WHO, UNICEF, USAID, MCHIP, PATH, NIPI, DFID, World Bank, KfW, and BMGF.**
- **Immunization Partners meetings are held periodically to support GoI in identifying areas for partner support and issues for strengthening the ongoing activities in Routine immunization. Three such meetings were held in 2011 on cold chain and RI related issues (the minutes of these partners meetings are attached).**
- **GoI launched revised RI monitoring strategy in July 2009 by including House to House (H-to-H) component along with modified session monitoring format. The monitoring is being conducted by the state government officials and partners in the states. The data generated is locally analyzed and shared within states/ districts. This concurrent RI monitoring and supportive supervision are ongoing in Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Orissa, Assam, and Jharkhand in collaboration with development partners. These formats were further revised and updated in June 2011.**
- **Periodic review meetings of Regional/ State level Cold chain officers and for the State EPI Officers were held at regular intervals and supported by development partners.**

5.2.2. If targets were not reached, please comment on reasons for not reaching the targets:

The target of pentavalent vaccine in India has not been reached as the introduction of vaccine was delayed due to a number of factors including the late supply of the vaccine by the manufacturer. Once vaccine was supplied to the states, there was a lag time of a few weeks before vaccine could reach to the district and sub-district level facilities, and finally introduced in the immunization program in these 2 states. Therefore, the targets were not met for the pentavalent vaccine.

For other vaccines/antigens in the UIP in India, this is not applicable.

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **yes, available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate
Coverage Evaluation Survey 2009	2009	

How have you been using the above data to address gender-related barrier to immunisation access?

The immunization program in India aims to provide vaccines to both male and female infants. The difference by Gender in various antigen coverage is evaluated in Coverage Evaluation Surveys. The last Coverage Evaluation Survey of 2009 reports that the differences in the coverage with various antigens is in the range of 1%. The coverage of the majority of the antigens in female child is slightly higher than male child.

If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? **Not selected**

What action have you taken to achieve this goal?

Not applicable.

5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)

It is often observed that the reported administrative coverage data of a few states/ districts is higher than the surveyed data and estimates. The Government of India has started electronic reporting of all immunization coverage data from the block and district level in the country. The immunization coverage data is being reported only through Health Management Information System (HMIS) and the other modes of immunization data reporting have been discontinued. However, the HMIS data entry process is very dynamic, where the data entry is done at the block and districts levels. The data is entered as and when received. The system is still maturing and there are issues related to the data quality and consistency. The process will take some more additional time before the process is stabilized. The states are being encouraged to look into the issues and the differences in reported and evaluated coverage during the the periodic SEPIO review meetings and also encouraged to verify/validate their reported coverage by comparing with the vaccine consumption in the districts.

The GoI has started an electronic name based Mother and Child Tracking System (MCTS). The states have started implementing MCTS and it is hoped that with the increased numbers of trainings, this system will evolve and help in improving data quality reporting in the country. This is also expected to track and inform beneficiary about the due antigens and help in increasing immunization coverage in India.

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

Coverage Evaluation Survey -2009 was conducted during 2010. <?xml:namespace prefix = st1 />
The Annual Health Survey in India was conducted in selected 8 states of the country in 2010-11 and the detailed analyzed data from this survey is awaited.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

Health Management Information System was introduced in October 2008. It is envisaged that the Health Statistics Information Portal system would facilitate the flow of physical and financial performance from the District level to the State HQ and the Centre using a web based Health Management Information System (HMIS) interface. There has been increased use of the HMIS portal and reporting is improving. However as described in section 5.3.1 above, there are still issues and challenges and continuous efforts are being made to address those issues at various levels by conducting review meetings and imparting trainings to the data entry operators and computer assistants. The training for use of HMIS system has been completed and currently all the states are sending their reports through HMIS. The system is expected to mature over time.

The initiatives started under NRHM (Alternate vaccine delivery system, regular review meetings, trainings of the various levels of functionaries etc.) are being consolidated for the improvement of data quality in <?xml:namespace prefix = st1 />India.

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

As described above, the HMIS will be further strengthened through feedback, review and trainings, as necessary. The process of data validation at various level and reducing typing errors has been ongoing.
The Govt. of <?xml:namespace prefix = st1 />India recognizes that strengthening and stabilization of data reporting through a web based system will take time and the needful support is being provided. There are still a few issues, however, no parallel system to report immunization related information is neither encouraged nor preferred.

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** and **Table 5.5b** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 51	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	**Expenditure Year 2011**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**To be filled in by country**	**To be filled in by country**	**To be filled in by country**
Traditional Vaccines*	46,410,000	46,410,000						
New and underused Vaccines**	7,280,000		7,280,000					
Injection supplies (both AD syringes and syringes other than ADs)	11,660,000	11,660,000						
Cold Chain equipment	0							
Personnel	0							

Other routine recurrent costs	310,000	310,000						
Other Capital Costs	0							
Campaigns costs	0							
To be filled in by country								
Total Expenditures for Immunisation	65,660,000							
Total Government Health		58,380,000	7,280,000					

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

Please state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

The Immunization program in India is implemented as part of the Reproductive and Child Health (RCH) program, which itself is a part of the overall umbrella of National Rural Health Mission in India. The common infrastructure and manpower, who deliver other health services is used for the delivery of immunization services in the country. Therefore, some of the information requested in the table above can not be provided. The available and relevant information for the table above has been added.

The partners support the Govt of India in various activities.

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

Not applicable.

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

Not applicable. In India, all traditional vaccines are procured through national government's internal funds.

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	53,580,000	
New and underused Vaccines**	31,420,000	
Injection supplies (both AD syringes and syringes other than ADs)	22,960,000	
Injection supply with syringes other than ADs		
Cold Chain equipment	44,520,000	
Personnel		
Other routine recurrent costs	600,000	
Supplemental Immunisation Activities		
Total Expenditures for Immunisation	153,080,000	

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

As per the description in the section 5.5.1, in the table above, the relevant and available information for immunziation program budgeting and financing has been provided. The budgetary allocations are done on the annual basis and the information for budgetary year 2013 will be provided in next APR.

There is no expected shortfall of funding for immunization program in India.

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

No.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 calendar year? **No, not implemented at all**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

Not applicable

If none has been implemented, briefly state below why those requirements and conditions were not met.

Not applicable.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **3**

Please attach the minutes **(Document N°)** from all the ICC meetings held in 2011, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

India's immunization program is fully internally funded program and therefore, there is no formal Inter-agency Coordination Committee (ICC) in the country. However, the technical assistance and inputs of the Development Partners are taken by the way of Immunization partner's meetings, National Technical Advisory Group of Immunization (NTAGI), Immunization Action Group, Technical working groups, during the review meetings, and at other appropriate fora. A number of coordination meetings of development partners and GoI were held in 2011, where issues related to immunization program were discussed.

- Immunization Partners meeting: 3 meetings of India Immunization Partners were held in 2011,
- National Immunization Program review meeting: A meeting of State EPI Officers was held in New <?xml:namespace prefix = st1 />Delhi on May 2011, where technical and operational issues related to immunization program were discussed. Another meeting of State Immunziation Officials and cold chain officers was held in April 2011.
- A number of Sub National level program review meetings for priority states were held in 2011. These meetings were attended by officials from select priority states and the necessary corrective programmatic suggestions were made in these meetings,
- The technical group of ministry officials and partners met on regular basis for the planning of Hib as pentavalent vaccine introduction in India

Some of the major issues discussed in-depth in the above meetings were:

- Strengthening Immunization coverage and reaching the unreached, reducing left-outs and drop-outs
- Drafting of National Vaccine Policy of India
- Recommendation for development of annual plans by GoI and States
- Implementation of MDVP in India
- Development of State PIPs and allocation of NRHM funds for RI
- Status of cold chain equipment, replacement of all CFC equipment
- Revision of micro-plans in UP and Bihar using data available from Polio Immunization Rounds
- Review of progress of HW and MO training in Routine Immunization
- Review of Hep B vaccine coverage in states and expansion of Hepatitis B vaccination in the entire country
- Introduction of Hib as pentavalent vaccine in select states of India.
- Status of JE vaccine campaigns and issues related to coverage in Routine Immunization
- Discussion on AEFIs in India and those related to Pentavalent vaccine in neighbouring countries
- Strengthening Human resources in immunization program in India
- Measles SIAs and their planning in India

Some of the areas noted with concern were:

- Varying political commitment
- Inability of RI to reach all children in spite of polio drops reaching almost every child
- Lack of coverage improvement plans in the states and districts

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
Indian Academy of Pediatrics

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for 2012 to 2013?

The year 2012-13 has been declared as the Year of Intensification of Routine Immunization (IRI) in India.

The efforts for the 'Intensification of Routine immunization' in India has already been started. The Government of India, with the support from immunization partners has developed National IRI operational guidelines. The Ministry of Health and Family Welfare has officially communicated IRI plans to all states. A few select states in the North Eastern Part of the country are already doing IRI activities and have already started Immunization Weeks. Additional priority states would do the activities planned in IRI including Immunization Weeks, in the months to come. <?xml:namespace prefix = o />

The Government has identified 239 priority districts for intensification activities of the total 641 districts. The strategies included in IRI plan for <?xml:namespace prefix = st1 />India includes prioritization of the states, districts and blocks for targeted activities to improve RI coverage. These priority districts are those districts with less than 50% fully immunized children as per DLHS 3 conducted in 2007-08. There are a series of planned activities including national and status level advocacy meetings, improved communication and social mobilization plan, regular program review meetings, development of coverage improvement plans by states, institutional capacity building, conducting Immunization weeks, strengthening RI monitoring and supervision, institutionalizing AEFI and VPD surveillance, strengthening partnership with all stakeholders, and conducting operational research studies.

●□□□□□□□□□□□□□□□□□□□□ The national operational guidelines for IRI and Immunization weeks have been finalized and shared with

the state officials.

●□□□□□□□□□□□□□□□□□□□□ The North Eastern states have initiated immunization weeks the Q1 2012 and while other states will do these Immunization weeks in later part of 2012.

●□□□□□□□□□□□□□□□□□□□□ Inter-departmental coordination mechanisms have been and will be set-up at all levels with states and districts creating “Task Force” committees to guide and monitor the programme.

●□□□□□□□□□□□□□□□□□□□□ Operational communication plans are being prepared by the states to focus on strategies for addressing the issues related to drop outs and increasing community participation in immunization.

●□□□□□□□□□□□□□□□□□□□□ States and districts will conduct risk analysis to identify and prioritize high risk blocks, gap analysis to identify bottlenecks in high risk areas, review and update the micro-plans of these areas and strengthen monitoring of session sites and community.

●□□□□□□□□□□□□□□□□□□□□ Rapid Response Teams formed under Emergency Preparedness and Response Plan (EPRP) will be involved to identify low coverage pockets, even in good performing districts,

●□□□□□□□□□□□□□□□□□□□□ Capacity building of the medical officers, Supervisors, ANMs and cold chain handlers will be expedited to be completed by 2013,

i. The Effective Vaccine Management (EVM) exercise will be conducted in all priority states to assess and strengthen cold chain and vaccine management,

ii. The “*Teeka Express*” van will be provided in select districts for vaccine delivery for outreach sessions; for visits to hard to reach areas and to conduct mobile clinics.

Additional activities scheduled for 2012:

- Medical officers and cold chain handlers training evaluation has been planned.
- Post Introduction evaluation of Pentavalent vaccine introduction in 2 states of India
- Measles SIAs will be conducted in additional districts of selected states of the country.
- Introduction of pentavalent vaccine in additional 6 states of the country,
- Sustaining the Polio free status of India will be ensured through timely and high quality polio SNIDs.
- Conducting EVM in select states of India

Moreover, the ongoing focus on the following RI strengthening will be sustained:

- Focus on reducing the left and drop outs in the priority states and improve coverage,
- Beneficiary (mother and child) tracking mechanism is being put in place in all states,
- Complete RI training of MOs and HWs in priority states,
- Strengthen HMIS and improve timely reporting of coverage data and VPDs,
- Strengthening and expanding RI monitoring in the states, encourage the States to conduct monitoring and use the data appropriately,
- Strengthen cold chain and Vaccine management especially at Divisional , State , GMSD and National level,
- Implementation of micro plans of RI,
- Implement Alternate Vaccine Delivery system,
- Conduct review meetings with State Immunization officers at least once in six months. States to conduct review meetings for DIOs regularly
- To conduct meetings with immunization partners regularly at national level at least once in a quarter and more frequently if necessary

All these priority areas and activities have been incorporated in the Draft MYP of India (2012-17).

Are they linked with cMYP? **Yes**

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011

BCG	AD Syringes	Internal funds of Govt of India
Measles	AD Syringes	Internal funds of Govt of India
TT	AD Syringes	Internal funds of Govt of India
DTP-containing vaccine	AD Syringes	Internal funds of Govt of India

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

No obstacle encountered.

Please explain in 2011 how sharps waste is being disposed of, problems encountered, etc.

The Hubcutters are being provided to all vaccinators, which are used for cutting of AD syringes immediately after the use. The Red and Black plastic bags are being provided for each session site for segregation and collection of immunization waste. This waste transported to the Primary Health Centre, where it is disinfected and disposed off, as per the Central Pollution Control Board guidelines in <?xml:namespace prefix = st1 ns = "urn:schemas-microsoft-com:office:smarttags" />India.

6. Immunisation Services Support (ISS)

India is not reporting on Immunisation Services Support (ISS) fund utilisation in 2012

6.1. Report on the use of ISS funds in 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*		
Remaining funds (carry over) from 2010 *(B)*		
Total funds available in 2011 *(C=A+B)*		
Total Expenditures in 2011 *(D)*		
Balance carried over to 2012 *(E=C-D)*		

6.1.1. Briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

6.1.2. Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.3. Request for ISS reward

Request for ISS reward achievement in India is not applicable for 2011

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2011 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	**Total doses for 2011 in Decision Letter**	**Total doses received by 31 December 2011**	**Total doses of postponed deliveries in 2012**
DTP-HepB-Hib		1,900,000	5,830,000

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  There was lower vaccine utilization in India in 2011, as the vaccination program could be started in Mid December 2011. However, as the supply of the vaccine was also delayed and the all amount proposed for 2011 was not delivered. Therefore, there was no excess stock in 2011.

  The pentavalent vaccine has replaced one vaccine vial each of DPT and Hepatitis B vaccine in these states, there was no issue of cold chain space in these 2 states. No vaccine doses were discarded because of VVM colour change or due to the passing of expiry date.

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  The regular review meetings with the states were held for the proper management of cold chain. It was ensured that states have sufficient numbers of cold chain equipments and the staff is well trained to maintain cold chain properly. Prior to the introduction of vaccine in these 2 states, operational guidelines were drafted for the introduction of pentavalent vaccine in the state. These guidelines covered all aspects including cold chain management. All categories of staff in these 2 states were trained, using these guidelines, including in the aspects related to the cold chain management.

7.1.2. For the vaccines in the **Table 7.1**, has your country faced stock-out situation in 2011? **No**

If **Yes**, how long did the stock-out last?

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced	Pentavalent vaccine	
Phased introduction	Yes	14/12/2011
Nationwide introduction	No	

The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	India has planned for the phased introduction of pentavalent vaccine. 2 states have introduced vaccine in 2011. It is proposed to introduce the vaccination in 6 additional states of India starting October 2012 onwards.

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **August 2012**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 20))

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2011 (A)	0	0
Remaining funds (carry over) from 2010 (B)	0	0
Total funds available in 2011 (C=A+B)	0	0
Total Expenditures in 2011 (D)	0	0
Balance carried over to 2012 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2011 calendar year (Document No 14) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

Not applicable

Please describe any problem encountered and solutions in the implementation of the planned activities

Not applicable

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

Not applicable.

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		

	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Not applicable.	

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

Not applicable.

Is GAVI's new vaccine support reported on the national health sector budget? **Not selected**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **October 2011**

Please attach:

(a) EVM assessment **(Document No 15)**

(b) Improvement plan after EVM **(Document No 16)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 17)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for for delay, if any
Provided Document no. 15	Provided in document no. 16	Provided in Document no. 17

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

General remark:

The table above allows for the entry of limited number of charecters. Therefore, it is not possible to provide information in the table above. The relevant information is being provided as summary documents enclosed with thsi APR. (Document no. 15 to 17).

The document no. 16 and 17 (on action recommonded in the improvement plan and implementation status) are inter-related. Therefore, the information on these two topics has been combined in single document.

When is the next Effective Vaccine Management (EVM) assessment planned? **July 2012**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

India does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

India does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2012

If 2012 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2013 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

Please enter current cMYP End Year: 2017

The country hereby request for an extension of GAVI support for

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

vaccines: for the years 2013 to .At the same time it commits itself to co-finance the procurement of

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

vaccine in accordance with the minimum GAVI co-financing levels as summarised in section 7.11 Calculation of requirements.

The multi-year extension of

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

vaccine support is in line with the new cMYP for the years 2013 to which is attached to this APR (Document N °**11**). The new costing tool is also attached.(Document N°**18**)

The country ICC has endorsed this request for extended support of

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

vaccine at the ICC meeting whose minutes are attached to this APR. (Document N°**21**)

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

Confirm here below that your request for 2013 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

Not Applicable.

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2011	2012	2013	2014	2015
DTP-HepB, 10 dose(s) per vial, LIQUID	10					
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2		2.182	2.017	1.986	1.933
HPV bivalent, 2 dose(s) per vial, LIQUID	2		5.000	5.000	5.000	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1		5.000	5.000	5.000	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10		0.242	0.242	0.242	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10		0.520	0.520	0.520	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10		0.494	0.494	0.494	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2		3.500	3.500	3.500	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1		3.500	3.500	3.500	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10		0.900	0.900	0.900	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5		0.900	0.900	0.900	0.900
Rotavirus, 2-dose schedule	1		2.550	2.550	2.550	2.550
Rotavirus, 3-dose schedule	1		5.000	3.500	3.500	3.500
AD-SYRINGE	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-PENTAVAL	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-YF	0		0.004	0.004	0.004	0.004
SAFETY-BOX	0		0.006	0.006	0.006	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2016
DTP-HepB, 10 dose(s) per vial, LIQUID	10	
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	1.927
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	1.927
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	1.927
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900
Rotavirus, 2-dose schedule	1	2.550
Rotavirus, 3-dose schedule	1	3.500
AD-SYRINGE	0	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047
RECONSTIT-SYRINGE-YF	0	0.004
SAFETY-BOX	0	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	500,000$	
			<=	>
DTP-HepB	HEPBHIB	2.00 %		
DTP-HepB-Hib	HEPBHIB		23.80 %	6.00 %
Measles	MEASLES	14.00 %		
Meningogoccal	MENINACONJUGATE	10.20 %		
Pneumococcal (PCV10)	PNEUMO	3.00 %		
Pneumococcal (PCV13)	PNEUMO	6.00 %		
Rotavirus	ROTA	5.00 %		
Yellow Fever	YF	7.80 %		

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2011	2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	1,633,000	2,467,750	4,990,000	5,037,000	14,127,750
	Number of children to be vaccinated with the first dose	Table 4	#	74,112	2,467,750	4,990,000	5,037,000	12,568,862
	Number of children to be vaccinated with the third dose	Table 4	#	0	2,467,750	4,990,000	5,037,000	12,494,750
	Immunisation coverage with the third dose	Table 4	%	0.00 %	100.00 %	100.00 %	100.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.33	1.33	
	Vaccine stock on 1 January 2012		#	1,485,814				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.18	2.02	1.99	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.00	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0058	0.0058	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00 %	6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2011	2012	2013	2014
Minimum co-financing	0.00	0.00	0.00	0.00
Recommended co-financing as per APR 2010				
Your co-financing			0.00	0.00

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2012	2013	2014
Number of vaccine doses	#	10,748,200	22,426,100	20,144,600
Number of AD syringes	#	10,868,000	19,409,400	16,825,300
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	120,650	215,450	186,775
Total value to be co-financed by GAVI	$	25,416,500	48,941,500	43,269,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2012	2013	2014
Number of vaccine doses	#	0	0	0
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0

Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country	$	0	0	0

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	74,112	2,467,750	0	2,467,750
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B X C*	222,336	7,403,250	0	7,403,250
E	**Estimated vaccine wastage factor**	*Table 4*	1.33	1.33		
F	**Number of doses needed including wastage**	*D X E*	295,707	9,846,323	0	9,846,323
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		2,387,654	0	2,387,654
H	**Stock on 1 January 2012**	*Table 7.11.1*	1,485,814			
I	**Total vaccine doses needed**	*F + G – H*		10,748,163	0	10,748,163
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		10,867,904	0	10,867,904
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		120,634	0	120,634
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		23,452,492	0	23,452,492
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		505,358	0	505,358
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		700	0	700
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		1,407,150	0	1,407,150
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		50,606	0	50,606
T	**Total fund needed**	*(N+O+P+Q+R+S)*		25,416,306	0	25,416,306
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		0		
V	**Country co-financing % of GAVI supported proportion**	*U / T*		0.00 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %			0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	4,990,000	0	4,990,000	5,037,000	0	5,037,000
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	14,970,000	0	14,970,000	15,111,000	0	15,111,000
E	Estimated vaccine wastage factor	*Table 4*	1.33			1.33		
F	Number of doses needed including wastage	*D X E*	19,910,100	0	19,910,100	20,097,630	0	20,097,630
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	2,515,945	0	2,515,945	46,883	0	46,883
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	22,426,045	0	22,426,045	20,144,513	0	20,144,513
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	19,409,399	0	19,409,399	16,825,251	0	16,825,251
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	215,445	0	215,445	186,761	0	186,761
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	45,233,333	0	45,233,333	40,007,003	0	40,007,003
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	45,233,333	0	902,538	40,007,003	0	782,375
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	1,250	0	1,250	1,084	0	1,084
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	2,714,000	0	2,714,000	2,400,421	0	2,400,421
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	90,379	0	90,379	78,346	0	78,346
T	Total fund needed	*(N+O+P+Q+R+S)*	48,941,500	0	48,941,500	43,269,229	0	43,269,229
U	Total country co-financing	*I x country co-financing per dose (cc)*	0			0		
V	Country co-financing % of GAVI supported proportion	*U / T*	0.00 %			0.00 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2012**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / T*

8. Injection Safety Support (INS)

India is not reporting on Injection Safety Support (INS) in 2012

9. Health Systems Strengthening Support (HSS)

India is not reporting on Health Systems Strengthening (HSS) fund utilisation in 2012

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. TYPE A: Support to strengthen coordination and representation of CSOs

India is not reporting on GAVI TYPE A CSO support for 2012

10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

India is not reporting on GAVI TYPE B CSO support for 2012

11. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2011 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2011 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2011 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	GAVI APR- FINAL MoHFW signed.pdf File desc: File description... Date/time: 5/20/2012 11:28:38 PM Size: 986973
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	GAVI APR- FINAL MoHFW signed.pdf File desc: File description... Date/time: 5/20/2012 11:28:38 PM Size: 986973
3	Signatures of members of ICC	2.2	✓	GAVI APR- FINAL MoHFW signed.pdf File desc: File description... Date/time: 5/20/2012 11:28:38 PM Size: 986973
5	Minutes of ICC meetings in 2011	2.2	✓	5. ICC Immunization partners meeting minutes India 2011.PDF File desc: File description... Date/time: 5/8/2012 7:25:01 AM Size: 653584
10	new cMYP APR 2011	7.7	✓	cMYP India_ May2012_v2.doc File desc: File description... Date/time: 5/21/2012 10:02:50 AM Size: 1067520
15	EVSM/VMA/EVM report APR 2011	7.5	✓	15. Final VMAand EVM fact sheet India.pdf File desc: File description... Date/time: 5/8/2012 12:38:03 AM Size: 3996373
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	16. Document 16 and 17 combined APR 2011 India.pdf File desc: File description... Date/time: 5/8/2012 12:36:02 AM Size: 107570
17	EVSM/VMA/EVM improvement implementation status APR 2011	7.5	✓	16. Document 16 and 17 combined APR 2011 India.pdf File desc: File description... Date/time: 5/8/2012 12:38:22 AM Size: 107570