GAVI Alliance

Annual Progress Report 2013

Submitted by

The Government of

India

Reporting on year: **2013**
Requesting for support year: **2015**
Date of submission: **15/05/2014**

Deadline for submission: 22/05/2014

Please submit the APR 2013 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: **2013**

Requesting for support year: **2015**

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	2014

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

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	2015	2016

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	No	next tranche: N/A	N/A
HSFP	Yes	Next tranch of HSFP Grant Yes	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 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	Dr Rakesh Kumar, Joint Secretary (Reproductive and Child Health), MoHFW, Govt. of India	**Name**	Economic Advisor, MoHFW, Govt. of India
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
Dr Nata Menabde/ WHO Representative	World Health Organization Country Office		

Mr. Louis Georges Arsenault , Country Representative	UNICEF Country Office		
Ms. Lise Grande , UN Resident Coordinator	UNDP		
Dr Vikram Rajan / Public Health Specialist	World Bank		
Mr. Sam Sharpe, Country Head	DFID, India Office		
Dr John Beed, Mission Director	USAID		
Ms. Frederika Meijer, Country Representative	UNFPA		

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

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), India , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC 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. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date
Immunization Advisory Group	Ministry of Health and Family Welfare		

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

All comments will be treated confidentially

Comments from Partners:

Minutes attached

Comments from the Regional Working Group:

Minutes attached

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

India is not reporting on CSO (Type A & B) fund utilisation in 2014

3. Table of Contents

This APR reports on India's activities between January – December 2013 and specifies the requests for the period of January – December 2015

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)					
	2013		2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation	Previous estimates in 2013	Current estimation
Total births	5,189,000	4,270,046	18,300,000	18,300,000		18,300,000		27,394,000
Total infants' deaths	199,000	147,981	768,600	768,600		768,600		1,287,518
Total surviving infants	4990000	4,122,065	17,531,400	17,531,400		17,531,400		26,106,482
Total pregnant women	5,707,000	5,548,088	20,130,000	20,130,000		20,130,000		31,503,100
Number of infants vaccinated (to be vaccinated) with BCG	5,189,000	4,739,810	18,300,000	18,300,000		18,300,000		27,394,000
BCG coverage	100 %	111 %	100 %	100 %		100 %		100 %
Number of infants vaccinated (to be vaccinated) with OPV3	4,990,000	4,451,881	17,531,400	17,531,400		17,531,400		26,106,482
OPV3 coverage	100 %	108 %	100 %	100 %		100 %		100 %
Number of infants vaccinated (to be vaccinated) with DTP1	4,990,000	1,256,974	17,531,400	17,531,400		17,531,400		26,106,482
Number of infants vaccinated (to be vaccinated) with DTP3	4,990,000	1,515,307	17,531,400	17,531,400		17,531,400		26,106,482
DTP3 coverage	100 %	37 %	100 %	100 %		100 %		100 %
Wastage*[1]* rate in base-year and planned thereafter (%) for DTP	4,990,000	25	17,531,400	17,531,400		17,531,400		26,106,482
Wastage*[1]* factor in base-year and planned thereafter for DTP	0.00	1.33	0.00	0.00		0.00		0.00
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	4,990,000	3,820,463	10,119,131	10,119,131		10,119,131		26,106,482
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	4,990,000	3,258,295	10,119,131	10,119,131		10,119,131		26,106,482
DTP-HepB-Hib coverage	100 %	79 %	58 %	58 %		58 %		100 %
Wastage*[1]* rate in base-year and planned thereafter (%) *[2]*	25	15	15	15		15		15
Wastage*[1]* factor in base-year and planned thereafter (%)	1.33	1.18	1.18	1.18		1.18		1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	0 %	25 %	0 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	4,990,000	4,457,699	17,531,400	17,531,400		17,531,400		26,106,482
Measles coverage	100 %	108 %	100 %	100 %		100 %		100 %
Pregnant women vaccinated with TT+	5,707,000	4,231,660	20,130,000	20,130,000		20,130,000		26,106,482

TT+ coverage	100 %	76 %	100 %	100 %		100 %		83 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0		0		0
Vit A supplement to infants after 6 months	0	0	0	0	N/A	0	N/A	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	-21 %	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.

2 GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

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 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2013.** The numbers for 2014 - 2014 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 target beneficiaries for the year 2013 are same as in the original submission on May2013 and represent the annual birth cohort of all 8 states which are proposed for ongoing pentavalent vaccination. These target beneficiaries do not include any proposed scale up beyond 8 states of India. The decision on any further scale up of pentavalent vaccine in India will be communicated to the GAVI alliance by theGovernment of India separately

The target beneficiaries for 2014 represents the annual birth cohort of 19states (8 states continuing vaccination in 2013 and 11 additional states, which are proposed to start vaccination in October 2014). These target beneficiaries have been modified in this update to incorporate proposed scale up in 11 states of India. Though, vaccination would start in these states in Oct2013, which covers only 3 months of a calendar year, this table is does not allow any modification to incorporate partial birth cohort. Thus these numbers are annual birth cohort and overestimate the total vaccine requirement for the year. This beneficiary number has been estimated by IRC in the IRC country report 27 Feb-7Mar 2014 in Table 3 where 100%annual target for 11 States starting from October 2014 and 16 States starting from April 2015 with 100% coverage has been presumed, which is not correct.This incorrect assumption has led to the incorrect cost projection of US$493.25million for 2015 & 2016.

MOHFWfigures for 2014 is 8,300,250 considering the 5,037,000 as the population ofeight states. And additional cohort of 3,263,250 as 25% population of 11 statesof Phase 2 (13,053,000), as provided in “Nationwide Scale up Hib as Pentadocument, Jan’14”. However, while calculating doses, October cohort may consume2 doses (4 & 10 weeks) and Nov and December cohort will use only one dose(4 weeks) of Penta.

The DPTfigures (DPT1 and DPT3) should be adjusted from 17,531,400 to more realisticnumber considering pentavalent introduction as new birth cohort of 19 stateswill be provided with Penta instead of DPT. The formualic tables dont allow for that

The Ministry requested for 100% Pentavalent vaccines with 100% coverage in the first year and for the subsequent year only replacement quantity is being asked which ranges from 60% to a maximum of 90%. The same principle would be applicable for expansion of Pentavalent to other States also.

As per the decision conveyed earlier, the Ministry would expand the Pentavalent vaccination in

a phased manner Thus, the targets should be considered accordingly. Though, there is no column for entering birth cohort for year 2015, the government of India would like to inform that Starting April2015, remaining 16 states and Union territories of India would also start the pentavalent vaccination. Thus, for the year 2015, the annual birth cohort targeted for pentavalent vaccination would be nearly 27.39 million.

FromApril 2016 onwards, the birth cohort would be covered by the Government ofIndia. The estimates for 2016 cover the entire national cohort of newborns (over 27 million) The number of infant deaths have been estimated using the current infant mortality Rate of 47/1000 live births. The numbers for pregnant women were estimated by increasing the number of newborns by 15% (to account for miscarriages/abortions etc).

- Justification for any changes in **surviving infants**

There is no change in the surviving infants for the 8 states that are proposed for pentavalent vaccination. However, as described above, when pentavalent vaccine is scaled up to additional states, the number of targeted surviving infants would increase.

However, as described above,the updated target beneficiaries for 2014 represents the annual birth cohort of 19 states (8 states continuing vaccination in 2013 and 11 additional states, which are proposed to start vaccination in October 2014). These target beneficiaries have been modified in this update to incorporate proposed scale up in 11 states of India. Though, vaccination in 11 additional states would start in Oct 2013, which covers only 3 months of a calendar year, this table is does not allow any modification to incorporate partial birth cohort. Thus these numbers are annual birth cohort.

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

The projections have been revised accordinglyassuming target of 80% of birth cohort and 15% wastage. The Ministry has projectedto supply the Pentavalent vaccine in 2014 anticipating the state wise targetsranging from 60% to a maximum of 90%.

- Justification for any changes in **wastage by vaccine**

India is doing phased introduction of pentavalent vaccine in the country. As has been discussed in the past with the GAVI Alliance and Development Partners, separate assumptions has to be taken for vaccine wastage rate for the states depending on the stage of pentavalent vaccine introduction.

Assumptions for estimating wastage

Based upon the experience from Post Introduction Evaluation in 2 states which started vaccination in 2011, the vaccine requirement can be calculated at the wastage rate of 10%. However, for the states where pentavalent vaccination is in the first year of implementation, a minimum wastage rate of 15% is proposed for calculating vaccine requirement. The states would need a buffer stock of 25% of annual requirement in the first year of introduction.

Important note: The tables in section 4 and section 7 are formulaic tables, which does not allow any modification. Therefore, the above assumptions could not be incorporated in the table in the section 4. Similarly, the tables in section 7 for vaccine requirement have been populated from section 4 and may not correctly reflect the vaccine requirement for India. These tables should be interpreted on the basis of assumptions provided above.

5.2. Immunisation achievements in 2013

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 2013 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 costs of AD syringes, Hubcutters & other injection safety & waste disposal material, and the cost of service delivery of immunization program in India are borne by theGovernment of India. As per the GoI discussions with the GAVI Alliance, this cost is considered the GoI's contribution for the new vaccine introduction(equivalent to the co-financing).

However, the APR submission web-portal has a pre-designed formulaic, which simultaneously calculate co-financing requirements. The online tool (or web-portal) does not allow country to make any modification; therefore, the co-financing component should not be taken into the consideration while reading this APR of India.

Major activities conducted and challenges faced in Immunization:

The Government of India has been fully supporting the Universal Immunization Programme (UIP) in the country, with own resources through National Rural Health Mission (NRHM). 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 funding for health from 0.9% of GDP to 2-3% of GDP. This has already reached to ~1.1% of GDP in the year 2011. 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 onHealth system strengthening and on improving Immunization program service delivery.

The overall health sector planning inIndia is done under the umbrella of Five Year Plans (FYP). India has finalized12th FYP for the period of 2012-17 and there is proposed increase of nearly335% budgetary allocation for health sector in comparison of 11th FYP of India.These initiatives are likely to benefit the health sector. Moreover, there is focus on launch of National Health Mission (NHM), which would be a combined program of existing NRHM and proposed National Urban Health Mission.

Progress in the ongoing activities:

- The year 2012-13 was declared as ‘Year of Intensification of Routine Immunization’ and a number of activities were done as part of year of IRI. The Government of India, with the support from immunization partners developed National IRI operational guidelines. The Ministry of Health andFamily Welfare had communicated IRI plans to all states. The Government had identified 239 priority districts for intensification activities of the total641 districts. The strategies included in IRI plan for India includes prioritization of the states, districts and blocks for targeted activities to improve RI coverage. These priority districts were those districts with less than 50% fully immunized children as per DLHS 3 conducted in 2007-08.There were a series of planned activities conducted 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 andVPD surveillance, and strengthening partnership with all stakeholders etc.

- The Govt. of India has been conducting regular review meetings with the states to strengthen RI in the country,

- Immunization weeks were conducted in selected states ofIndia to increase coverage with the antigens.
- National Vaccine Policy of India has been released in 2011and comprehensive Multi Year Strategic Plan (MYP) for UIP in India (2012-17) has been approved

Improving Service Delivery

- The Multi Dose Vial Policy (MDVP) for HepB Birth dose andOPV zero dose was introduced in the entire country in the mid 2011. The MDVPwas further expanded to the pentavalent vaccine in 2 states in 2011 and toother states where pentavalent vaccine was introduced in 2012.
- Decentralized planning and need based funding through NRHMand state Project Implementation Plans (PIPs) is being done in India
- Use of polio infrastructure for identification of high riskareas for RI has been started and missed areas have been incorporated into RImicro plans and regular sessions are being conducted.
- There is increased emphasis on cold chain strengtheningthrough expansion and replacement of CFC equipment. There has been increasedfocus on web based cold chain management information system in India.
- Provision of alternate vaccine delivery mechanism andprovision of alternate vaccinator for under-served urban and rural areas,
- Provision of 2nd ANM at Sub centers in difficult to accessareas and in the poor performing states,
- Improving mobilization for immunization and improvedtracking to reduce drop outs through Accredited Social Health Activist (ASHA)hired at village level (>800,000 hired Source: NRHM),
- Increasing institutional deliveries through cash incentivebased scheme *Janani Suraksha Yojana*(JSY).

Intensified Routine Immunization Training of Front-line workers

- During the “Year of Intensification of RoutineImmunization” (2012-13), Government of India decided to conduct an intensified and focused training of frontline workers with the objective of enhancing the operational and interpersonal skills of these workers. The goal of this training is to improve the coverage and quality of routine immunization services by reaching the children that have been missed so far.
- There is an initial focus on 9 priority states namely Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Chhattisgarh, Jharkhand, Haryana,Gujarat and West Bengal as these states have a large number of missed children.The training materials have been finalized and the training of trainers and monitoring the training of the frontline workers such as ANMs, LHVs, Anganwadi workers and ASHAs is being done. Nearly 1,250,000 front line workers are to be trained in these states.
- Training materials were developed and printed e.g. Infokits for Health workers and ASHA/AWW; the Facilitators’ guide for the trainers;presentations and films on IPC and RI.
- Training modules for Block level program managers supporting immunization were prepared in India and distributed.

Monitoring of RoutineImmunization Program in India

- The RI monitoring formats have been further revised in 2012 andwidely disseminated amongst the states. The intensified monitoring efforts areongoing in Bihar, Uttar Pradesh, Jharkhand, and a few other states. There hasbeen increased RI monitoring by the government officials and increasingly morenumber of states have started using the RI monitoring formats.
- A new RI monitoring data tool was prepared by WHO and widelyshared with all states to facilitate the data analysis and timely feedback. Thediscussion on revised monitoring formats and tools were held in all majornational and state level UIP review meetings.
- The trainings in RI monitoring have been conducted in a number ofstates, which plans to roll-out the RI monitoring in India. Punjab, Maharashtraand West Bengal states have also started reporting on the RI monitoring data.
- WHO and other partners are extensively supporting RI monitoring instates such as Bihar and Uttar Pradesh while state governments have takenownership in additional states such as Karnataka, Maharashtra and Haryana.

AdverseEvents Following Immunization Surveillance

There is a thrust on strengthening AEFIsurveillance in the country for last few years. This has resulted in theincreasing trends in the reporting of serious AEFI cases in India. In the year2012, a total of 333 serious AEFI cases were reported from 148 districts of21states of the country.

- National AEFI committee constituted in January 2008. Thestate AEFI committees have been constituted in all 35 States. Followingintroduction of new guidelines, regular trainings are conducted at state level(for sensitization of District AEFI committee members and Immunization ProgramManagers). In 2012; Maharashtra, Kerala, Chhattisgarh and Haryana conductedstate level workshops and nearly 150 officials were trained in these workshops.In 2012, AEFI trainings were conducted for private practitioners also, in thestates of Uttar Pradesh and Bihar.
- India joined the WHO Global Network of Post MarketingSurveillance (PMS) with Maharashtra state of India being the participatingstate. The initial training in the software tool for data entry was conductedin the month of August 2010, followed by another training in Sept 2011.Maharashtra state had started reporting to PMS network in the month ofMarch2012.
- The AEFI surveillance and response operational guidelineswere revised in 2010. A total of 25,000 copies of these guidelines have beenprinted and widely disseminated, to be distributed to all members of State anddistrict AEFI committees and for health facilities up to Primary Health centerlevel in India. In 2011, an abridged version of National AEFI standardoperating procedures were prepared and printed. 40,000 copies of theseguidelines had been printed and disseminated amongst medical officers acrossthe country.
- To strengthen reporting of AEFI in states introducing LPV,state level AEFI workshops were conducted in Kerala and Haryana in 2012.Similar workshops are planned for 2013 for other states introducing LPV .
- As part of the Measles SIAs preparation, the trainings ofdistrict and state level officials have been conducted in AEFI surveillance andreporting on all measles SIA districts in 14 states.
- National AEFI committee met three times in 2012 andreviewed various surveillance aspects. Besides, regular monthly meetings ofstakeholders in AEFI and Pharmacovigilance were conducted in 2012 to shareupdates.
- The National level causality assessment working groupconducted the causality assessment of 72 cases available in the nationaldatabase in 2012. Training of national and state AEFI Committees is scheduledin 2013 to further strengthen the AEFI causality assessment process in

India.

- □□□□□□An AEFI Secretariat was established in partnership withPHFI and funding support from WHO. A senior technical position was filled andrecruitment of additional staff is under process.

A National regulatoryAuthority (NRA) assessment was done in India in 2012, which had emphasis onAEFI surveillance in the country also. The NRA teams visited Haryana and Keralastates of the country. The AEFI surveillance was found satisfactory and Indiawas declared passed in NRA assessment.

Accelerated measles control

India introduced measles second dose(MCV2) for all children in the country starting from November 2010. A total of21 states which had MCV1 coverage more than 80%, have introduced the measles second dose in UIP at 16 – 24 months of age at the time of 1st DPT booster. 14states, which had MCV1 coverage of <80% have initiated measles SupplementaryImmunization Activities, followed by the introduction of MCV2 in UIP, after 6months of completion of campaigns in their respective districts . In these campaigns, a total of ~140 million children from 9 months to less than 10 years old in 367 districts were targeted for vaccination in a phased approach. Phase1 of the campaign was conducted in 45 districts and vaccinated ~12 million children. In phase II, a total of ~36 million children in 153 districts of 14states were vaccinated. Up till the end of Dec. 2012, while phase III measles catch up campaigns was underway, 94 districts from 5 states had vaccinated around 33 million of the targeted 86 million children in this final phase. Following activities have been done for Measles SIAs in India with partner support:

- Development and printing of national operational guidelines and vaccinators module for measles SIAs in India
- Training of state and district-level trainers in measlesSIA districts and states, through state TOT (Training of Trainers) and district planning workshops.
- Establishment of adverse events following immunization(AEFI) management networks in all the campaign and training of district and block medical officers (> 9,000 medical officers trained till the end ofDec. 2012).
- In the year 2012, with technical support from WHO-India,NPSP and in collaboration with the Integrated Disease Surveillance Project(IDSP), laboratory supported measles surveillance has been expanded to,1additional state of Haryana. This lab. supported measles surveillance is established on the existing AFP surveillance network, after conducting the state and district launch workshops to train all state program officers,DIOs(district immunization officers) and DSOs (district surveillance officers),including all the BMOs (block medical officers) in the state.
- By the end of Dec. 2012, the ongoing laboratory based measles surveillance system has been operational in 12 states of India (Assam, Andhra Pradesh, Bihar, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Rajasthan, Tamil Nadu and West Bengal).

Introduction of JapaneseEncephalitis (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.
- □□□□□□The repeat campaigns for JE vaccine were conducted in selected districts in 2011 and 2012.

- Based upon the epidemiological profile and NTAGI discussions, the Government of India made a policy decision for the use of 2 dose schedule forJE vaccine in endemic district of India in 2012.

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 of these 10 states.

- Starting 2011/12, the Hepatitis B vaccination program has been scaled up to the entire country with Government of India's own funds. The vaccine has become the 7th antigen to be part of UIP across the country.

- The hepatitis B vaccination program is successfully running in all states of the country, is continuously reviewed and monitored through various approaches.

Introduction of Hib asPentavalent 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.

- The GoI has introduced the HIb as Pentavalent vaccine in 2 states namely Tamil Nadu and Kerala in 2011, six more states - Goa, Gujarat, aryana , Jammu & Kashmir, Karnataka and Puducheery introduced the vaccine by March 2013.

- A Post Introduction Evaluation (PIE) of pentavalent vaccine was conducted by WHO India along with other partner institutions and government organization in March 2013. The findings of this PIE were widely disseminated and used for corrective measures in these 8 states and also for the scale up of the pentavalent vaccination in additional states of India in 2014 (FinalPIE report is attached as enclosure 9).

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,UNOPS/NIPI, DFID, World Bank, KfW, BMGF and Immunization Technical Support Unit(ITSU).

  - 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. A total of 8 major meetings were held in 2012, which were attended and participated by Development Partners. These seven meetings include three national level RI review meetings and meeting each of Immunization Action Group (IAG), India Immunization partners forum, national technical Advisory Group on Immunization (NTAGI), national level cold chain review meetings and meeting on communication for Intensification of RI inIndia. New vaccine introduction was discussed in all these meetings.

- GoI launched revised RI monitoring strategy in July 2009 by includingHouse 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 2012.

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.

ColdChain and Vaccine Logistics Strengthening

· National EVMassessment and improvement plan were developed and are included in the report as attachments

· National ColdChain MIS implemented in 100% districts of India for improved andreal-time management of cold chain system

· National Cold Chain and Vaccine management Resource Center (NCCVMRC) was established at NIHFW,Delhi and National Cold Chain Training Center NCCTC at Pune

· Real-time Vaccine Logitics MIS was tested in Odisha and Bihar and and electronic Vaccine Intelligence Network (eVIN) solution system was piloted in two districts of UP. The vaccine logistics systems will be scaled up in 8 high priority states between 2014-16, as part of the GAVI HSS grant

· National Coldchain and vaccine Logistics Action Plan concept is approved by MOHF onmajor activities to address the challenges faced in immunization.

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

The targets were met in 2 states of India where pentavalent vaccination had started in 2011(Tamil Nadu and Kerala). However, the targets of pentavalent vaccine could not be reached for other states where vaccination was supposed to be scaled up in 2012. This was attributable to a number of factors including the late supply of the vaccine to the additional states (there was no delay in the supply of the vaccine to Kerala and Tamil Nadu). Besides of the additional 6 states that scaled up Penta, the scale up process started only from the 2nd quarter onwards. Hence the targets could not be entirely met for the year.

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls

Coverage Evaluation Survey	2009	71.5%	71.4%

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

The immunization program in India aims to provide vaccines to allchildren irespective of gender. The difference in coverage bygender in various antigens is evaluated in the Coverage EvaluationSurveys. The last Coverage Evaluation Survey of2009 has reported that the differences in the coverage withvarious antigens was in the range of 1%.

As per CES-2009; thecoverage with various antigens in male and female child was as follows: BCG(Male: 86.4%; Female: 87.5%); OPV3: (Male: 70.2%; Female: 70.7%); Measles:(male 74.8%; female: 73.2%); Fully Immunized (Male: 61.9% and Female: 59.9%);No immunization (Male: 7.9%; Female: 7.2%).

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

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)

Currently the most reliable estimates of immunization coverage come from the CES conducted by UNICEF. The last CES was conducted in 2009.

It is often observed that the reported administrative coverage data of a few states/ districts is higher than the surveyed data and the 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 ManagementInformation System (HMIS) and the other modes of immunization data reporting have been discontinued.

The HMIS data entry process is very dynamic, where the data entry is done at the block and districts levels.The is entered as and when received. The system is still maturing and there are issues related to the data quality and consistency. The process is likely to take some more time before it could be stabilized.

As part of streamlining this process,the states are being encouraged to look into the issues and the differences in reported and evaluated coverage during 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) in the country. The states have started implementing MCTS and it is hoped that with the increased numbers of trainings, this system will also 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 2013 will only be available in July 2014 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **Yes**

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

- The Annual Health Survey (AHS) in India was conducted in selected 9 states of the country in 2010-11.

The District LevelHousehold Survey (DLHS), fourth round was conducted in 2012. The data is being analyzed and the findings from this survey will be released in 2014.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2011 to the present.

Health Management Information System (HMIS) was introduced in India 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 5.4.1 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 the 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, Block monitoring, supportive supervision assisting data quality improvements, regular review meetings, trainings of the various levels of functionaries etc.) are being consolidated for the improvement of data quality in 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.

There has been increasing focus on improving HMIS performance in India. The HMIS data is regularly reviewed at the national level and immediate feedback is provided to the respective state officials. During the regular review meetings, the feedback is provided to the states and issues are discussed.

The visits to various levels are utilized for necessary support for improving the performance of HMISin India. There has been encouraging reports and the system has shown the signs of improvement

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** 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$ = 57	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 2013	Source of funding						
		Country	GAVI	UNICEF	WHO	NA	NA	NA
Traditional Vaccines*	46,822,807	46,822,807	0	0	0	0	0	0

New and underused Vaccines**	27,970,175	0	27,970,175	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	10,752,632	10,752,632	0	0	0	0	0	0
Cold Chain equipment	4,961,404	4,961,404	0	0	0	0	0	0
Personnel	0	0	0	0	0	0	0	0
Other routine recurrent costs	0	0	0	0	0	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	33,142,105	33,142,105	0	0	0	0	0	0
Grant-in-aid to States		552,632	0	0	0	0	0	0
Total Expenditures for Immunisation	123,649,123							
Total Government Health		96,231,580	27,970,175	0	0	0	0	0

* 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.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2014 and 2015

Not applicable.

All traditional vaccines in India are procured through a budgetary alllocation by the National Government

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 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?
Not Applicable	No

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 2013? **6**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 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 by the national government and, there is no formal Inter-agency Coordination Committee (ICC) in the country. However, the technical assistance and inputs of the DevelopmentPartners are taken by mode of India Immunization partner's meetings,National Technical Advisory Group of Immunization (NTAGI), Immunization ActionGroup (IAG), Technical working groups, during the national level review meetings,and at other appropriate

fora

- A meeting of the NTAGI Standing Technical Sub Committee (STSC) meeting was held in August 2013 where it was recommended that pentavalent vaccine be scaled up nationwide in a logistically structured manner which implied that monitoring of AEFI is to be done carefully, while introducing the vaccine in new states to ensure public safety and concernsThe national AEFI committee met in August 2013 where it endorsed the findings of its causality sub committee that the AEFI deaths reported in Kerala were not causally associated with Pentavalent vaccine
- A meeting of NTAGI was held in September 2013 where it endorsed the recommendation of the STSC regarding the scale up of Pentavalent vaccine and issues concerning Penta AEFI
- India A meeting of Immunization Action Group (IAG) was held in October 2013 where partners were apprised of the status of the Health Systems Strengthening (HSS) proposal with GAVI. It was informed that HSS proposal has been approved. In this regard, the chair requested each HSS implementing organization (UNICEF, UNDP and WHO) to submit an implementation plan for HSS grant for next 6 months to the Ministry.
- A meeting of the Mission Steering Group (MSG) was held in December 2013 to discuss the introduction and scale up of Pentavalent vaccine. The members discussed issues around AEFI and referred to the earlier discussion on the same subject in the STSC and NTAGI meetings. The MSG recommended for a phase-wise scale up of Pentavalent vaccine across the country through 2014 and 2015 India Immunization Partners meeting was held in January 2014 where the scale up of Pentavalent vaccine was discussed
- A meeting of India Immunization Partners was held in January 2014 to discuss the preparation of GAVI APR 2013. The meeting also discussed about the then upcoming PIE to be conducted in March 2014. The members were appraised on the Government's proposed scale up of Pentavalent vaccine in 2014 and 2015.
- A review meeting of GAVI HSS partners was held in the Ministry in March 2014 under the chairmanship of Joint Secretary (RCH) to appraise the ministry of the partners progress in the implementation of HSS grant during the 1st quarter of 2014.

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

If Yes, which ones?

List CSO member organisations:
Indian Academy of Pediatrics (IAP)
Indian Medical Association (IMA)

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI programme for 2014 to 2015

- The introduction and scale up of pentavalent vaccine in the states would be closely monitored and states would be provided regular support and technical assistance for smooth inclusion of vaccine in state programs.The vaccine will be expanded to a further 11 states during 2014 and the rest of the country in 2015.

Country will implement the GAVI HSS project with a focus on innovative technology to strengthen vaccine logistic and cold chain mechanisms in 8 States in 2014-15.

Government will explore the options of introducing IPV as part of post -eradication strategy for Polio

Learning from the Polio eradication program legacy, the State and district level task forces for Routine immunization will be formed. These task forces will regularly review the immunization program performance and will supplement the efforts of other mechanisms and review meetings besides providing a systematic platform for interactions by various stakeholders working in the area of RI at various levels.

The focus on the identification of missed areas for RI willbe retained and improvement in RI micro-plans followed by attention on regularimmunization sessions in those areas will be paid. These efforts will also bemonitored through the existing intensified RI monitoring.

- The RI monitoring efforts will be further intensified andscale up to the additional states of India. The efforts and attention will bepaid to increase the monitoring by the government staff at various levels.
- • States and districts will continue to conduct risk analysisto identify and prioritize high risk blocks, gap analysis to identifybottlenecks in high risk areas, review and update the micro-plans of theseareas and strengthen monitoring of session sites and community.
- The immunization program Performance will be reviewedthrough regular UIP review meetings held at various levels, on timelyintervals.
- India would continue to conducted Effective VaccineManagement (EVM) assessment in 2014. The findings of EVMassessment would be utilized for preparation of detailed cold chain improvementplan and to strengthen cold chain and vaccine management in the country.
-

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 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
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 2013 how sharps waste is being disposed of, problems encountered, etc.

The Hub-cutters are being provided to all vaccinators (ANMs) in UIP in India, 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. The safety pits for immunization waste are being constructed under funding provided through NRHM in India. In addition, a number of states in the country have developed public private partnership for immunization and hospital waste disposal mechanism.

In general, the immunization waste is transported to the Primary Health Centre, where it is disinfected and

disposed off, as per the Central Pollution Control Board (CPCB) guidelines in India

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2013

India is not reporting on Immunisation Services Support (ISS) fund utilisation in 2013

6.2. Detailed expenditure of ISS funds during the 2013 calendar year

India is not reporting on Immunisation Services Support (ISS) fund utilisation in 2013

6.3. Request for ISS reward

Request for ISS reward achievement in India is not applicable for 2013

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

7.1. Receipt of new & under-used vaccines for 2013 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2013 vaccinations against approvals for 2013

	[A]	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
DTP-HepB-Hib	21,419,000	12,854,000	0	No

**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? ...)

  Most of the challenges in vaccine stock management have been identifed in the national EVM assessment carried out in 2013 which included the 8 GAVI Penta states as well (report attached). Some key findings suggest

  - There is a need to improve overall vaccine logisticsmanagement system in the country
  - There arechallenges in distribution of vaccines between each supply chain level
  - Wastagereporting system needs to be strengthened in most states

  Some States delayed the vaccination program despite having received the vaccines on time, this resulted in a lower utilization of the planned vaccinnation

- 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)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

  - 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 additional 6 states, operational guidelines for pentavalent vaccine introduction were updated, and widely disseminated. These guidelines covered all aspects including cold chain management. All categories of staff in these states were trained, using these operational guidelines.
  - The findings from Post Introduction Evaluation conducted in the 8 implementing states had been used corrective measures and additional

planning in states scheduled for scaling up of pentavalent vaccine.

A national level EVM was conducted in March-April 2013, which included the eight states that have introduced Pentavalent vaccine. The recommendations of this exercise shall inform the Pentavalent vaccine management interventions in these states and help prepare the remaining states for an eventual nationwide scale of the vaccine in 2014

- The vaccine and logistics management practices are being strengthened through various mechanisms. A number of field evaluations including deep-dive exercise conducted by ITSU; evaluation of cold chain system in collaboration with INCLEN and vaccine freezing assessment by Indian Council of Medical Research have been carried out in India contributing to further strengthening of vaccine storage practices.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

Not Applicable

7.2. Introduction of a New Vaccine in 2013

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2013, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	Yes	01/12/2011
Nationwide introduction	Yes	01/03/2015
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 pentavalent vaccine in 2011. A total of 6 additional states of India - Jammu &Kashmir, Gujarat, Goa, Haryana, Karnataka and Puducherry, wer e cheduled to start pentavalent vaccination by October 2012 but only one state (Haryana) could start vaccination then. By March 2013 the remaining five states also introduced the Pentavalent vaccine. By Oct 2014 a further 11 States will introduce the vaccine and by March 2015, the vaccine introduction will be scaled up to the entire country

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **March 2014**

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° 9))

A summary of the key recommendations from PIE 2014 are as follows

Recommendations

Planning andintroduction of LPV and MCV2

- □ □I □□It is recommended that detailed operational plans should bedrawn up three to four months prior to introducing a new vaccine. States anddistricts should review their preparedness through standard checklists.Operational guidelines should be updated and made available at all levels.States should be allowed to introduce new vaccines after their preparedness hasbeen reviewed and found to be satisfactory.

- □ □ □ □A ceremonial launch for introduction of the vaccine should beheld at the state and district levels, with the involvement of media, communityand professional bodies. The gap between the launch and actual start ofimmunization should be as short as possible.

Programme stewardship

- □□□□□Every state should have afunctioning state task force for immunization (STFI) and district task forcesfor immunization (DTFI) to regularly review and guide the vaccine introductionand immunization programme. A system for regular review and feedback at thestate should be put in place, especially for high-priority districts.

- □□□□□The presence of a nationaldignitary or celebrity or political leadership at the launch of the vaccinewould increase the visibility and public confidence.

- □□□□□Private practitioners and professional medical bodies should beconsulted and involved in the new vaccine introduction.

Humanresources

- □□□□□It is recommended that all existing staff vacancies should befilled at the earliest, and staff deployment

rationalized.

•□□□□□The immunization management structure should particularly bestrengthened at state and district levels. One district immunization officershould be posted in each district and large urban bodies.

Microplanning

•□□□□□It is recommended that the polio experience should be used toupdate RI microplans. High-risk areas that have been mapped under the polioprogramme should be included in routine immunization microplans in alldistricts. Rationalized session plans should be prepared to include high-riskareas, including urban slums and missed areas, so that vulnerable populationsare not missed.

Training andknowledge of healthcare workers

•□□□□□All health workers should be trained before introduction of newvaccine on operations and interpersonal communications. Additionally, short,frequent trainings should be held for frontline health workers using materialsdeveloped by WHO NPSP and other partners.

•□□□□□Medical officers from alternative streams of medicine andmedical college staff should also be trained for new vaccine introduction andimmunization.

Health financing

•□□□□□Funds for the introduction of vaccine should be ensuredbeforehand.

•□□□□□The existing health workers such as ASHA should be timely paidtheir incentives and other dues. This is important to ensure their motivationand commitment.

Cold chainmanagement

•□□□□□Cold chain should be reviewed and strengthened before vaccineintroduction. A cold chain mechanic should be positioned in each district.

•□□□□□It is recommended that a quarterly review of district cold chainhandlers should be organized at the state level and on a monthly basis at thedistrict level.

•□□□□□Recording of temperatures in ILRs and deep freezers should bedone regularly even on weekends.

Vaccine,transport and logistics management

•□□□□□Vaccine management should be strengthened so that forecastingand indenting are accurate to avoid stock-outs or excess vaccines.

•□□□□□Health workers should be trained to administer pentavalentvaccine to all eligible beneficiaries. There should be no discrimination basedon migratory status, i.e., both residents and migrants should get the samevaccine.

Supervisionand monitoring

•□□□□□The Immunization Field Volunteer (IFV) model should be used tostrengthen monitoring and micro-planning.

•□□□□□Supportive supervision model should be strengthened in prioritydistricts through identified state nodal officers.

•□□□□□Standard RI monitoring formats circulated by the MoHFW, GoIshould be used to document supervisory visits and analyzed to provide feedback.At health facilities, feedback of supervisory visits should be recorded onregisters for follow up on corrective actions.

•□□□□□Vehicles should be provided to enable supervisory visits inhard-to-reach areas.

•□□□□□Cold chain and vaccine management should also be monitored.

Coverage, reportingand data collection

- □□□□□Data entry portals should beupgraded in the HMIS software before the vaccine launch.
- □□□□□Analysis of pre- andpost-introduction coverage and vaccine wastage rates should be part of theguidelines for the introduction of new vaccines. A standardized RImonitoring chart should be used for monitoring progress at the primary healthcentre.
- □□□□□Reporting forms and immunization cards should be updated toinclude columns for recording of new vaccines. Health workers should be trainedto correctly fill in the immunization cards and other forms.
- □□□□□The data collected from paper reports and HMIS/MCTS should bechecked for accuracy, analyzed and used to provide feedback to improveprogramme performance and fill in gaps.
- □□□□□Due lists should captureinformation on beneficiaries up to the age of two years.

Surveillancefor adverse events following immunization

- □□□□□Capacity of health care workers should be strengthened foridentifying and reporting AEFI.
- □□□□□All adverse effects following immunization(AEFI) should be investigated promptly, as this helps to establish causalityand builds trust among the community.
- □□□□□AEFI kits should be in placeduring all immunization sessions and health workers should be trained on theuse of AEFI kit.
- □□□□□Media handling of AEFI should besensitively done so that the community is not alarmed. Districtofficials should be trained on media handling.
- □□□□□Private practitioners should also be sensitized to the need forreporting and managing AEFI cases.

Open vial policy/multi-dosevial policy

- □□□□□All health workers need to be sensitized on the Open Vial Policy(OVP) and how to follow it correctly in order to reduce vaccine wastage.
- □□□□□Vaccine wastage records should be analyzed to identifypoor-performing areas and corrective action taken.

Injectionsafety and waste management

- □□□□□Outsourced models of wastemanagement work better than the model of making the PHC responsible fordisposal of waste through waste pits. States should consider adopting thesemodels for more efficient waste management.
- □□□□□Safety pits should be constructed as per the guidelines. Itshould be ensured that waste is safely disposed of even after it leaves thesite.
- □□□□□Adequate numbers of hub cutters, and black and red bags shouldbe available at immunization sites.
- □□□□□Health workers should be trained on injection safety and wastemanagement guidelines.

Advocacy,social mobilization and communications

- □□□□□It is recommended that advocacy be conducted both before thelaunch of a new vaccine and periodically thereafter to highlight the benefitsand increase awareness.
- □□□□□IEC materials should be prepared and be available prior to thelaunch. Programme branding should be ensured.
- □□□□□It is recommended that all states should strengthen theirprint/electronic media engagement and handling plans to increase publicawareness.
- □□□□□States should harness allcommunications channels print, electronic and social media. Benefits of thevaccine should be reinforced through the media.

- □□□□□Information, education andcommunications (IEC) materials should be clear, attractive and easy to read.They should provide focused messages and contain adequate information about thevaccine. If necessary, they should be translated into the local language forwider dissemination.

- □□□□□IEC materials should be available in sufficient quantities andfreely distributed. Health facilities should prominently display posters.

Communityacceptance of the vaccines

- □□□□□It is recommended that IEC materials (both written andpictorial) prepared in local language be made available to the community.

- □□□□□Capacity building of frontline health workers on communicationsskills is highly recommended. Health workers equipped with good communicationsskills will be able to mobilize the community to accept vaccines.

- □□□□□Health workers should be informed and trained on the importanceof follow up of drop-outs, and educate caregivers on the consequences.

- □□□□□Health workers should also deliver the four key messages to allcaregivers and enter the next due date of immunization on the cards.

Privatesector involvement in vaccination

- □□□□□It is recommended that the private sector should be activelyinvolved in immunization activities from prelaunch stage, including reportingof vaccine preventable diseases and AEFI. Private practitioners should beincluded in training and monitoring.

Lessonsincorporated from the polio programme

- □□□□□IIt is recommended that programme reviews should be continuedthrough state and district task force meetings on immunization.

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**

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

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Yes**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

The NTAGI StandingTechnical Sub Committee meeting held in August 2013 discussed on the issue ofhospital-based sentinel surveillance for bacterial meningitis and recommendedthat sentinel surveillancesystems be further established and enhanced in expansion states in a phasedmanner to represent population of different states gradually over a period oftime and the trend of Hib infection be tracked.

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	0	0
Remaining funds (carry over) from 2012 (B)	0	0
Total funds available in 2013 (C=A+B)	0	0
Total Expenditures in 2013 (D)	0	0
Balance carried over to 2014 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 calendar year (Document No 10,11) . 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 2014 onwards

Not Applicable

7.4. Report on country co-financing in 2013

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0	0
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?	
Government	0	
Donor	0	
Other	0	

	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0	0
	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	April	GOVERNMENT
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Response to Q.1 to Q5: 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 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	

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 support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **No**

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? **March 2013**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

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

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

If yes, provide details

When is the next Effective Vaccine Management (EVM) assessment planned? **June 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

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 2014

If 2014 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 2015 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 2015 to 2016.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 2015 to 2016 which is attached to this APR (Document N°**16**). The new costing tool is also attached.(Document N°**17**)

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°**18**)

7.9. Request for continued support for vaccines for 2015 vaccination programme

In order to request NVS support for 2015 vaccination do the following

Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	200,000$		250,000$	
			<=	>	<=	>
DTP-HepB	HEPBHIB	2.00 %				
HPV bivalent	HPV	3.50 %				
HPV quadrivalent	HPV	3.50 %				
Measles second dose	MEASLES	14.00 %				
Meningococcal type A	MENINACONJUGATE	10.20 %				
MR	MR	13.20 %				
Pneumococcal (PCV10)	PNEUMO	3.00 %				
Pneumococcal (PCV13)	PNEUMO	6.00 %				
Rotavirus	ROTA	5.00 %				
Yellow Fever	YF	7.80 %				

Vaccine Antigens	VaccineTypes	500,000$		2,000,000$	
		<=	>	<=	>
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50 %	6.40 %		
HPV bivalent	HPV				
HPV quadrivalent	HPV				
Measles second dose	MEASLES				
Meningococcal type A	MENINACONJUGATE				
MR	MR				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Yellow Fever	YF				

7.11. Calculation of requirements

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

ID		Source		2013	2014	2015	2016	TOTAL
	Number of surviving infants	Table 4	#	4,990,000	17,531,400	17,531,400	26,106,482	66,159,282
	Number of children to be vaccinated with the first dose	Table 4	#	4,990,000	10,119,131	10,119,131	26,106,482	51,334,744
	Number of children to be vaccinated with the third dose	Table 4	#	4,990,000	10,119,131	10,119,131	26,106,482	51,334,744
	Immunisation coverage with the third dose	Table 4	%	100.00 %	57.72 %	57.72 %	100.00 %	

	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.18	1.18	1.18	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	5,636,000				
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	5,636,000				
	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	
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	$		0.0450	0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

0

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

Co-financing group	Intermediate

	2013	2014	2015	2016
Minimum co-financing	0.00	0.00	0.00	0.00
Your co-financing	0.00	0.00	0.00	0.00

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

		2014	2015	2016
Number of vaccine doses	#	35,822,000	26,207,500	92,417,000
Number of AD syringes	#	33,393,200	22,817,500	86,151,400
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	367,325	251,000	947,675
Total value to be co-financed by GAVI	$	78,153,500	54,595,000	192,777,000

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

		2014	2015	2016
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 [1]	$	0	0	0

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

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	4,990,000	10,119,131	0	10,119,131
B1	Number of children to be vaccinated with the third dose	*Table 4*	4,990,000	10,119,131	0	10,119,131
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	14,970,000	30,357,394	0	30,357,394
E	Estimated vaccine wastage factor	*Table 4*	1.33	1.18		
F	Number of doses needed including wastage	*D X E*		35,821,725	0	35,821,725
G	Vaccines buffer stock	*((D - D of previous year) x 0) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0)*		0	0	0
H	Stock to be deducted	*H1 - F of previous year x 0*				
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*				
H2	Reported stock on January 1st	*Table 7.11.1*	0	5,636,000		
H3	Shipment plan	*UNICEF shipment report*		39,800,000		
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		35,822,000	0	35,822,000
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		33,393,134	0	33,393,134
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		367,325	0	367,325
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		72,038,042	0	72,038,042
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		1,502,692	0	1,502,692
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)*		1,837	0	1,837
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		4,610,435	0	4,610,435
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*		78,153,006	0	78,153,006
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 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

		Formula	2015			2016		
			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 4*	10,119,131	0	10,119,131	26,106,482	0	26,106,482
B1	Number of children to be vaccinated with the third dose	*Table 4*	10,119,131	0	10,119,131	26,106,482	0	26,106,482
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	30,357,393	0	30,357,393	78,319,446	0	78,319,446
E	Estimated vaccine wastage factor	*Table 4*	1.18			1.18		
F	Number of doses needed including wastage	*D X E*	35,821,724	0	35,821,724	92,416,947	0	92,416,947
G	Vaccines buffer stock	*((D - D of previous year) x 0) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0)*	0	0	0	0	0	0
H	Stock to be deducted	*H1 - F of previous year x 0*	9,614,277	0	9,614,277			
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*	9,614,276	0	9,614,276			
H2	Reported stock on January 1st	*Table 7.11.1*						
H3	Shipment plan	*UNICEF shipment report*						
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	26,207,500	0	26,207,500	92,417,000	0	92,417,000
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	22,817,428	0	22,817,428	86,151,391	0	86,151,391
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	250,992	0	250,992	947,666	0	947,666
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	50,344,608	0	50,344,608	177,533,057	0	177,533,057
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,026,785	0	1,026,785	3,876,813	0	3,876,813
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)*	1,255	0	1,255	4,739	0	4,739
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	3,222,055	0	3,222,055	11,362,116	0	11,362,116
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	54,594,703	0	54,594,703	192,776,725	0	192,776,725
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 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

   b. HSS implementation during January – April 2014 (interim reporting)

   c. Plans for 2015

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2014, the HSS reports are expected by GAVI Alliance by September 2014.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2013

   b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2013 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2013 and request of a new tranche

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **No**

If NO, please indicate the anticipated date for completion of the HSS grant.

31st December 2016

Please attach any studies or assessments related to or funded by the GAVI HSS grant.

Please attach data disaggregated by sex, rural/urban, district/state where available, particularly for immunisation coverage indicators. This is especially important if GAVI HSS grants are used to target specific populations and/or geographic areas in the country.

If CSOs were involved in the implementation of the HSS grant, please attach a list of the CSOs engaged in grant implementation, the funding received by CSOs from the GAVI HSS grant, and the activities that they have been involved in. If CSO involvement was included in the original proposal approved by GAVI but no funds were provided to CSOs, please explain why not.

Not Applicable

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

Please provide data sources for all data used in this report.

Please attach the latest reported National Results/M&E Framework for the health sector (with actual reported figures for the most recent year available in country).

9.1.1. Report on the use of HSS funds in **2013**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **41150000** US$

These funds should be sufficient to carry out HSS grant implementation through December 2015.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	0	27610000
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	0	27610000
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	0	27610000

Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	0	27610000
Total expenditure during the calendar year (*D*)	0	0	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	0

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	41150000	38250000	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	41150000	38250000	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0
Total expenditure during the calendar year (*D*)	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	27610000	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	41150000	0	0

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	0	0
Total expenditure during the calendar year (*D*)	0	0	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	0

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0
Total expenditure during the calendar year (*D*)	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2008	2009	2010	2011	2012	2013
Opening on 1 January	0	0	0	0	54	57
Closing on 31 December	0	0	0	0	54	57

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2014 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

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

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 HSCC in this process.

NA

Has an external audit been conducted? No

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2013 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Not Applicable			

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Not Applicable	

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

The funds for GAVI HSS were received by the implementing partners - WHO, UNICEF and UNDP in December 2013 and were thus not utilized during the year. The project interventions will commence in 2014

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Not Applicable

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2012 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	**Baseline**		**Agreed target till end of support in original HSS application**	**2013 Target**						**Data Source**	**Explanation if any targets were not achieved**
	Baseline value	**Baseline source/date**			**2009**	**2010**	**2011**	**2012**	**2013**		
Not Applicable											

9.4. Programme implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service

programmes, and how the HSS funds benefited the immunisation programme

Programme implementation will commence in 2014

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

Not Applicable

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

Not Applicable

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

Not Applicable

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

Not Applicable

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

Not Applicable

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

Not Applicable

9.5. Planned HSS activities for 2014

Please use **Table 9.5** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
Strengthen vaccine logistics and cold chain management in poor performing states through public-private partnerships and through improved human resources capacity, institutional strengthening and supporting supervision	1. Improve human resources to improve cold chain performance 2. Supportive supervision to ensure quality implementation 3. Implement EVM improvement plans 4.Institutional capacity building to	5010000				

	strengthen the cold chain system 5. Implement Public-Private Partnership Models for Vaccine Logistics and Cold Chain Management					
Design and implement an eVIN that will enable real time information on cold chain temperatures and vaccine stocks and flows	1. Scale up a system for SMS-enabled real-time MIS for cold chain and VLM 2. Human resource and capacity building for vaccine intelligence	2010000				
Increase demand for RI through a national BCC strategy	1. Implement a multi-pronged, national BCC strategy development and operational plan with a special emphasis on priority states 2.Enhance infrastructure and HR capacity to develop and implement BCC strategies 3. Develop and broadcast immunization messages through mass media, mid media, new media, and IPC 4. Promote advocacy with media to create an enabling environment for increasing demand for RI services (current and new vaccines)	7160000				
Strengthen the evidence base for improved policy-making (at all levels) in programmatic areas like procurement and vaccine delivery and on sequencing and adoption	1. Build the capacity of existing institutions at the national, state, district, and block levels in generating and interpreting evidence through measles and	2530000				

of new antigens	other VPD surveillance mechanisms for improved policy-making 2. Expand model based strategy development approaches to support policy decisions in seven additional states 3. Support evidence generation to assess the case for new antigens based on system readiness, avertable burden, programme costs, and cost-effectiveness.					
Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery in 8 priority states	1. Identification and enumeration of high risk populations 2. Intensive RI Monitoring 3. Link AFP surveillance to UIP reviews 4. Technical support to the state and district RI task forces in key high priority states 5. Build capacity of frontline workers at state and district levels in high priority states	5810000				
Program Management		5090000				
		27610000	0			0

9.6. Planned HSS activities for 2015

Please use **Table 9.6** to outline planned activities for 2015. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Strengthen vaccine logistics and cold chain management in poor performing states through public-private partnerships and through improved human resources capacity, institutional strengthening and supporting supervision	1. Improve human resources to improve cold chain performance 2. Supportive supervision to ensure quality implementation 3. Implement EVM improvement plans 4.Institutional capacity building to strengthen the cold chain system 5. Implement Public-Private Partnership Models for Vaccine Logistics and Cold Chain Management	8450000			
Design and implement an eVIN that will enable real time information on cold chain temperatures and vaccine stocks and flows	1. Scale up a system for SMS-enabled real-time MIS for cold chain and VLM 2. Human resource and capacity building for vaccine intelligence	8670000			
Increase demand for RI through a national BCC strategy	1. Implement a multi-pronged, national BCC strategy development and operational plan with a special emphasis on priority states 2.Enhance infrastructure and HR capacity to develop and implement BCC strategies 3. Develop and broadcast immunization messages through mass media, mid media, new media, and IPC	7220000			

	4. Promote advocacy with media to create an enabling environment for increasing demand for RI services (current and new vaccines)				
Strengthen the evidence base for improved policy-making (at all levels) in programmatic areas like procurement and vaccine delivery and on sequencing and adoption of new antigens	1. Build the capacity of existing institutions at the national, state, district, and block levels in generating and interpreting evidence through measles and other VPD surveillance mechanisms for improved policy-making 2. Expand model based strategy development approaches to support policy decisions in seven additional states 3. Support evidence generation to assess the case for new antigens based on system readiness, avertable burden, programme costs, and cost-effectiveness.	3310000			
Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery in 8 priority states	1. Identification and enumeration of high risk populations 2. Intensive RI Monitoring 3. Link AFP surveillance to UIP reviews 4. Technical support to the state and district RI task forces in key high priority states 5. Build capacity of frontline workers at state and	6960000			

	district levels in high priority states				
Programme Management		6540000			
		41150000			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
None			

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?

Please attach:

1. The minutes from the HSCC meetings in 2014 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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 **has NOT received GAVI TYPE A CSO support**

India is not reporting on GAVI TYPE A CSO support for 2013

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

India **has NOT received GAVI TYPE B CSO support**

India is not reporting on GAVI TYPE B CSO support for 2013

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 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & 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 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & 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 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & 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 2013	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	✓	Signature1.pdf **File desc:** , **Date/time :** 13/05/2014 08:34:35 **Size:** 2 MB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature1.pdf **File desc:** **Date/time :** 13/05/2014 08:36:04 **Size:** 2 MB
3	Signatures of members of ICC	2.2	✓	SIGNATURE .pdf **File desc:** **Date/time :** 11/05/2014 11:46:44 **Size:** 4 MB
4	Minutes of ICC meeting in 2014 endorsing the APR 2013	5.7	✓	Meeting Minutes Jan 2014.docx **File desc:** **Date/time :** 11/05/2014 11:51:30 **Size:** 25 KB
5	Signatures of members of HSCC	2.3	✓	Attachment.pdf **File desc:** **Date/time :** 13/05/2014 08:43:31 **Size:** 14 KB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3	✓	Document 6 (1).pdf **File desc:** **Date/time :** 12/05/2014 12:58:43 **Size:** 7 KB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	No file loaded
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3	✗	No file loaded
9	Post Introduction Evaluation Report	7.2.2	✓	PIE report_13052014.pdf **File desc:** **Date/time :** 15/05/2014 12:33:29 **Size:** 4 MB

10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	Document 10.pdf **File desc:** **Date/time :** 12/05/2014 01:03:53 **Size:** 26 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1	✓	Dcoument 11.pdf **File desc:** **Date/time :** 12/05/2014 01:06:51 **Size:** 36 KB
12	Latest EVSM/VMA/EVM report	7.5	✓	National EVM-SD Ver 3.5 29th nov 2013 (1).pdf **File desc:** **Date/time :** 12/05/2014 12:08:28 **Size:** 13 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	Attachment 13.pdf **File desc:** **Date/time :** 13/05/2014 04:49:44 **Size:** 17 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM Implementation plan and progress - Apr 2014.xls **File desc:** **Date/time :** 13/05/2014 04:46:12 **Size:** 59 KB
16	Valid cMYP if requesting extension of support	7.8	✗	Multi-Year Strategic Plan 2013-17 (2).pdf **File desc:** **Date/time :** 12/05/2014 06:04:19 **Size:** 17 MB
17	Valid cMYP costing tool if requesting extension of support	7.8	✗	No file loaded
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	No file loaded
19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	Attachment.pdf **File desc:** **Date/time :** 13/05/2014 08:45:05 **Size:** 14 KB

20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	Attachment.pdf **File desc:** **Date/time :** 13/05/2014 08:46:40 **Size:** 14 KB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3	✓	Document 21.pdf **File desc:** **Date/time :** 12/05/2014 01:20:10 **Size:** 23 KB
22	HSS Health Sector review report	9.9.3	✓	Attachment.pdf **File desc:** **Date/time :** 13/05/2014 08:48:06 **Size:** 14 KB
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2013)	10.2.4	✗	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4	✗	No file loaded
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2013 on (i) 1st January 2013 and (ii) 31st December 2013	0	✓	Attachment.pdf **File desc:** **Date/time :** 13/05/2014 08:38:27 **Size:** 14 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✗	No file loaded
	Other		✗	HSS Progress report Jan-Apr2014 .pdf **File desc:** GAVI HSS Progress report Jan- Apr 2014 **Date/time :** 13/05/2014 08:31:11 **Size:** 635 KB

				GMSD Strengthening Plan.docx **File desc:** GSMD improvement plan (as required in the IRC country report (India) 27Feb-7 March 2014) **Date/time :** 15/05/2014 02:53:20 **Size:** 140 KB Minutes NCCVLAP.docx **File desc:** National Cold Chain Action Plan - Concept note. (as required in the IRC country report (India) 27Feb-7 March 2014) **Date/time :** 15/05/2014 03:00:39 **Size:** 27 KB NCLAP-Concept note.docx **File desc:** National Cold Chain Action Plan - Concept note. (as required in the IRC country report (India) 27Feb-7 March 2014) **Date/time :** 15/05/2014 02:57:10 **Size:** 53 KB