Joint appraisal report

Country	**India**
Reporting period	*July 2014 – August 2015*
cMYP period	*2013-2017*
Fiscal period	*April 2014 to March 2015*
Graduation date	*2017-2021 (expected)*

1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

The Universal Immunization Programme (UIP) is among the major child health interventions in India that aim to achieve the reduction in infant and child mortality. The UIP attempts to immunize 27 million children annually and is one of the largest public health programs in the world. It is implemented as part of an integrated set of interventions of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH + A) programme launched by Government of India (GOI) in 2013. The programme offers currently traditional vaccines, will scale-up the pentavalent programme nation-wide by the beginning of 2016, envisages to introduce IPV in 2015 and to include Rotavirus vaccine at a limited regional scale funded from national resources.

WUENIC 2014 revised Indian coverage rates significantly upward even retroactively since 2009 (DTP3 at 83%, OPV3 82%, MCV1 83%) which is a recognition of the long-time improvements of the implementation and monitoring of the UIP.

Gavi currently supports the pentavalent programme (US$ 265m) until 2016 and the IPV programme (US$ 30.6m) with 12 months of catalytic support. The Gavi HSS grant (US$ 107 million) will be implemented from 2014-2016 and focuses on 12 states and 127 underperforming districts. The components of the programme are addressing the main causes of coverage and equity deficits of the immunisation system.

Government of India finances 90% of the universal program expenditure. Other sources of financing were WHO (4%), UNICEF (3%) and GAVI (3%) underscoring the sustainability of national financing of immunization. The total cost of immunization program (routine and supplemntary Immunization) as of 2012 is 718.03 million USD, which amounts to 0.03% of the Gross Domestic Product (GDP) and 1% of total health expenditure in the country. However, with multiple planned vaccine introductions and necessary infrastructure investments the financial needs of the programme will increase considerably in the coming years.

The Modi government is since July 2014 committed to an ambitious immunization agenda and announced the introduction of 4 new vaccines (IPV, MR, Rota, JE (adult) in the UIP in 2015 and 2016. The Ministry of Health and Family Welfare (MoHFW) has also initiated a number of activities to improve immunization coverage and equity, specifically Mission Indradhanush (meaning Rainbow) which focuses on improvements of coverage and equity in 201 low-performing districts across the country. The HSS grant is synergistic to this mission.

India is now projected to cross Gavi's new income eligibility threshold in 2017 (rolling average over three years of GNI p.c. above US$ 1610) and transition out of Gavi support until 2021.

Against the background of the ending of the current active Gavi support in 2016, the ambitious immunization agenda of the government and the entry of the country into the transition phase,

the Gavi Board has requested the Secretariat to develop a strategy to engage with India for 2016-2021. The strategy includes three key components (coverage and equity, new vaccine support and market shaping) and will will be presented to the PPC in October and the Board in December 2015.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- Nationwide scale-up of penta implemented with minor delays which will be completed by the beginning of 2016.
- Commitment and planning to introduce IPV in accordance with the Polio Endgame Strategy and assurance by government to take over full financial responsibility after conclusion of Gavi and GPEI support.
- WUENIC coverage estimates have been improved retrospectively across all antigens (DTP 3 at 83%) for the first time since 2009 recognizing UIP's constant improvements
- Successful launch of MoHFW's coverage and equity initiative Mission Indradhanush across underperforming Districts in India.
- Implementation of the HSS grant with innovative components (e.g. eVIN system, leveraging the Polio experience for RI, comprehensive EVM assessments, cold chain improvements)

Challenges

- India still has 4.1 million un-immunized children and wide regional variances of coverage estimated. "Reach Every Child" maintains to be a priority.
- Planning penta procurements and delivery schedules for multiple state wise introductions is complex and delayed some important introductions (e.g. Uttar Pradesh).
- Insufficient IPV dose allocations for the nationwide introduction required new planning and resulted in delays.
- Progress of specific components of the HSS grant lagging behind because of late signature of PFA in July 2015 and late disbursements of HSS funds as a consequence.
- Implementation status of the national M&E platform requires acceleration.
- Critical EVM assessments and urgency to improve and rehabilitate the cold chain and vaccine logistics systems.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

Pentavalent programme:

- Continue regular dialogue and progress updates on the roll-out to the remaining 16 states and monitor dose shipment schedules and requirements.
- MoHFW to inform Gavi about national procurement of penta vaccine from FY 2016/17 onwards.

IPV programme:

- Continue dialogue about the vaccine dose requirements for the first 12 months of support.
- MoHFW to inform Gavi and GPEI about national procurement of IPV vaccine after conclusion of Gavi/ GPEI support

HSS programme:

- Finalize ToR for mid-term evaluation in Q4 2015
- Update Performance Framework of the grant

• "National M&E Plan for Immunisation" has been drafted and is now under review. It is necessary to confirm the finalisation and start the implementation of this plan.
IAG (Immunization Action Group) • Strengthen IAG by pre-dictable scheduling and agenda setting. 3-4 meetings annually should be envisaged as agreed upon during the Join Appraisal in 2014

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals
New and underused vaccine support • No grant renewals for the penta and IPV programme are requested as the funds are fully approved **Health systems strengthening support** • Approval of a new tranche of HSS funding of US$ 39 million for 2016

1.4. Brief description of joint appraisal process

The Joint Appraisal was done remotely. MoHFW, ITSU and UN agencies were requested for specific inputs following the JA guidelines. Gavi Secretariat drafted the report. The information is based on the submitted APR and frequent mission to India in the first half of 2015 and the respective follow-up.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

India will not achieve the Millennium Development goals of reduction in under five mortality and infant mortality. At the national level, it is estimated that India has a under-five mortality rate of 53 per 1000 live births (target 42/1000) and an infant mortality rate of 41 per 1000 live births (missing the target of 27/1000) [1.] Reducing infant morbidity and mortality continues to be an important goal for the Government of India. The 'National Policy for children 2013' commits to providing universal access to services for prevention of neonatal and childhood illnesses. The Universal Immunisation Programme (UIP) in India is implemented as part of the integrated set of interventions of reproductive, maternal, new born, child and adolescent health (RMNCH+A) which are a component of the National Health Mission+ which is the overarching sector programme in India. MoHFW also co-hosted in August 2015 the Call to Action Summit 2015 for ending preventable child and maternal deaths.

India presently accounts for approximately 20 per cent of the world's child deaths (1.4 million). Among children who die before their fifth birthday, almost one third of them die of infectious causes, nearly all of which are preventable. As per WHO –CHERG 2014 estimates, the causes of child mortality in the age group 0-5 years in India are (a) neonatal causes (55%),

[1] "Countdown to 2015" data. The "Millennium Development Goals India Country report 2014. Social Statistics Division, Ministry of Statistics and Programme Implementation, Government of India." has slightly older figures (e.g. U5MR 52/1000, IMR 42/1000) www.mospi.in

(b) pneumonia (12%), (c) diarrhoeal disease (10%), (d) measles (2%), (e) injuries (4%) and (f) others (15%).

India has the largest birth cohort (approx. 27 million[1]) and accounts for 4.1 million (28%) of the 14.8 million children under-immunized in currently Gavi eligible countries WUENIC 2014 retrospectively increased the coverage estimates since 2010 for India and DTP3 is at 83% . This is a recognition of the overall improvements of the UIP and its monitoring data.

With the Modi government, there is a renewed commitment to immunisation at the highest levels of Government in India. Following the announcement of the Prime Minister's Office (PMO) in July 2014 to introduce 4 new vaccines into the UIP in 2015 (IPV, MR, Rota and JE), the Ministry of Health and Family Welfare (MoHFW) introduced Japanese Encephalitis vaccine in endemic districts for adults this year and inactivated polio vaccine planning is well underway for a Q4 2015 launch. For Rota vaccine, India has budgeted a small pilot introduction in <10% of the birth cohort in 2016. The National Technical Advisory Group on Immunisation (NTAGI, NITAG equivalent) recently recommended the introduction of PCV.

The country was declared Polio free in 2014 and also announced elimination of maternal and neonatal tetanus ahead of schedule in 2015. The nationwide scale-up of the Gavi supported penta programme will be completed by the beginning of 2016. This marks significant achievements for the country's Universal Immunisation Programme (UIP).

MoHFW has developed its own initiative to improve coverage and equity called Mission Indradhanush (MI, meaning Rainbow) which seeks to improve coverage and equity of immunisation through targeted interventions in 201 high focus districts. The objective is for 90% of all India's children to be fully immunised by 2020 (based on India's national immunisation schedule)[2]. The first four rounds of MI were conducted from April to July 2015 and reached 2 million unimmunized children. The initiative is synergistic to Gavi's HSS grant. This renewed momentum represents a major opportunity to improve coverage and equity in India.

India is now projected to cross Gavi's new income eligibility threshold in 2017 (rolling average over three years of GNI p.c. above US$ 1610) – one year later than previously anticipated.

Against the background of the ambitious immunization agenda and the entry into the transition phase, the Gavi Board has requested the Secretariat to develop a strategy to engage with India as it transitions out of Gavi support (2017-2021). The strategy has been conceptualized based on the May 2015 PPC-endorsed principles for engagement and three key components of the strategy (coverage and equity, new vaccine support (MR, Rota, PCV, HPV), and market shaping). The paper was developed in an intensive dialogue with government and partners and will be presented to the PPC in October 2015 for review and recommendation to the Board in December 2015. It includes a very detailed analysis of the Indian UIP and options for its future development.

Partnership Framework Agreement

India has signed Gavi's **Partnership Framework Agreement** (PFA) in July 2015. This was a pre-requisite for further disbursements for the HSS grant and has led to some delays in the implementation of the grant (see below).

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

[1] Based on India country data, UNDP has a lower estimate by ~3m births

[2] FIC : BCG, OPV3, DTP3/ penta, measles,

3.1.1. Grant performance and challenges

The UIP includes vaccinations to prevent DTP (replaced by penta), polio, measles, severe forms of childhood tuberculosis, hepatitis B (HepB), haemophilus influenzae type B (Hib) infections (replaced by penta), and Japanese encephalitis (in selected districts).

The currently **active Gavi support to the UIP** are the pentavalent and IPV programmes.

From 2003 to 2009, Gavi provided catalytic funding to India to support the introduction of **hepatitis B vaccine** (HepB US$26m) vaccine as well as **injection safety** (auto disable syringes) in routine immunisation (US$18m). At the completion of Gavi support, GoI took over financial ownership of these two programme areas and maintained its support since. National scale up of **Hepatitis B monovalent** vaccine has taken more than 10 years with many implementation challenges. The **injection safety** was scaled up nationally with domestic resources within two years

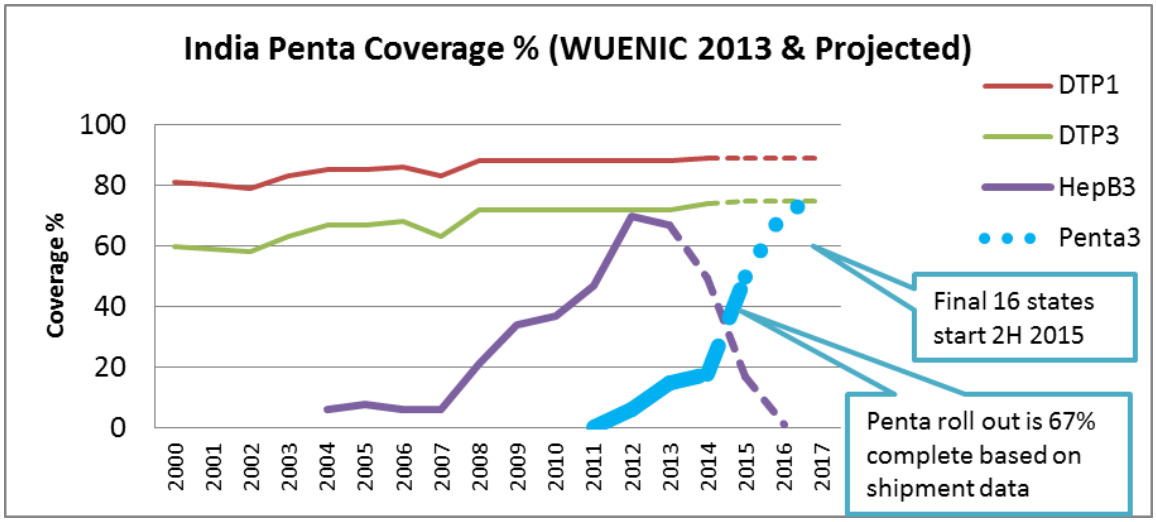
Pentavalent Programme

Gavi's support for pentavalent totals to US$ 265m. The grant started in 2011with a limit of ~US$120m funding (which was the balance of funds left after HepB and injections safety from the US$165m funding cap set by the Board at that time). The Board subsequently relaxed the limit allowing for the grant to be increased to US$ 265m (decision June 2012 and June 2014).

Following the HLRP review in July 2014, the co-financing requirements by government of 1/3 of the dose requirements in the final year of the scale-up have been waived by Gavi in October 2014 because of implementation problems and government's commitment to fully self-finance the programme from 2016 onwards only.

The pentavalent programme started in 2 states (Kerala, Tamil Nadu) in Dec 2011 and by 2013 8 states had introduced the vaccine (Goa, Gujarat, Haryana, Jammu and Kashmir, Karnataka and Puducherry). Based on key lessons learnt and recommendations from Post Introduction Evaluations, the use of pentavalent vaccine was further scaled up in 12 states during 2014-15 (Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Jharkhand, Madhya Pradesh, Punjab, Rajasthan, Telangana, Uttarakhand and West Bengal). By mid-2015 20 of 36 states, representing 67% of the annual birth cohort, are using the vaccine.

India now plans to launch the pentavalent vaccine in the remaining 16 states/UTs in the second half of 2015 (A&N Islands, Arunachal Pradesh, Chandigarh, D&N Haveli, Daman & Diu, Himachal Pradesh, Lakshadweep, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Sikkim, Tripura and Uttar Pradesh). The preparations for this activity are already in progress. The introduction in Uttar Pradesh is very likely to be delayed to January 2016 (state readiness issues and constrained supplies schedules through UNICEF-SD).



Gavi issued an updated Decision Letter for the programme in March 2015 as consequence of the reduced penta price to US$ 1.6 p.d. (WAP). With the remaining funds the entire estimated requirements of 2015 and Q1 2016 will be financed by Gavi. The increased flexibilities of Gavi's support were an important step ahead to facilitate the implementation of the programme for government.

The financial commitment which GoI has made for penta from FY2016 onwards remains to be operationalized. It will be important to monitor progress in India's plans to take over the financing (e.g. procurement process, financial planning).

Based on the strong local manufacturing capabilities for penta, the transition to local procurement after Gavi support presents minimal risks to programme sustainability and could also present opportunities for future cost saving for both Gavi and India due to a significant overlap of manufacturers supplying penta.

The pentavalent vaccine and IPV rollout experiences (see below) have shed light on challenges regarding vaccine demand forecasts and accommodation of the country's existing distribution system. These aspects require closer Alliance-wide cooperation for the implementation of ongoing and future programmes.

Polio and IPV

India had a tremendous success in **polio** eradication. It is polio free for over four years (since January 13, 2011) and this has helped to bring other immunisation issues to the forefront of public health policy in the country.

After an unexpected application to Gavi in September 2014, the IPV programme has been approved by the Gavi and GPEI Boards. In consultation with GPEI, Gavi decided to offer support for one year – the first year of introduction from Q4 2015 – of vaccine supplies for a nationwide introduction. Support is dependent on the commitment of the Government of India to self-finance the programme after conclusion of Gavi support and the availability of additional earmarked funding from GPEI to Gavi. GoI accepted this condition in a letter to Gavi and GPEI in March 2015. Bill & Melinda Gates Foundation (BMGF) committed US$ 30.6m to support the Indian IPV programme. Gavi issued a DL in June 2015.

Instead of a simultaneous national rollout, the **introduction of IPV** is now scheduled for October/ November in a 3-phase manner across the country, targeted to be completed by Q1 2016 (Phase-I: 21 states/UTs in November 2015. Phase II: 9 states in January 2016.

Phase III: 6 states/UTs in March 2016). Preparation for the IPV introduction are being implemented (state level workshops and trainings etc.).

The delay is due to constrained global supplies and a discrepancy in funding requirements to meet the country's estimated demand. MoHFW, WHO, UNICEF and Gavi worked out alternative phased introduction scenarios (on the basis of 29m doses available for 12 months) and improved logistical support for imported vaccines to government with deliveries to consignee points at state level.

MoHFW re-iterates in the context of the JA the issue of insufficient dose allocations (29 million) for the one year of IPV support and requests GPEI and Gavi to consider additional dose allocations and financial support. According to the plan up to 39 million doses are needed assuming 100% coverage (MoHFW's calculation in the first year of the introduction of a vaccine) and up to 32 million doses are required with actual DTP3 coverage rates.

Coverage & Equity and Data Quality

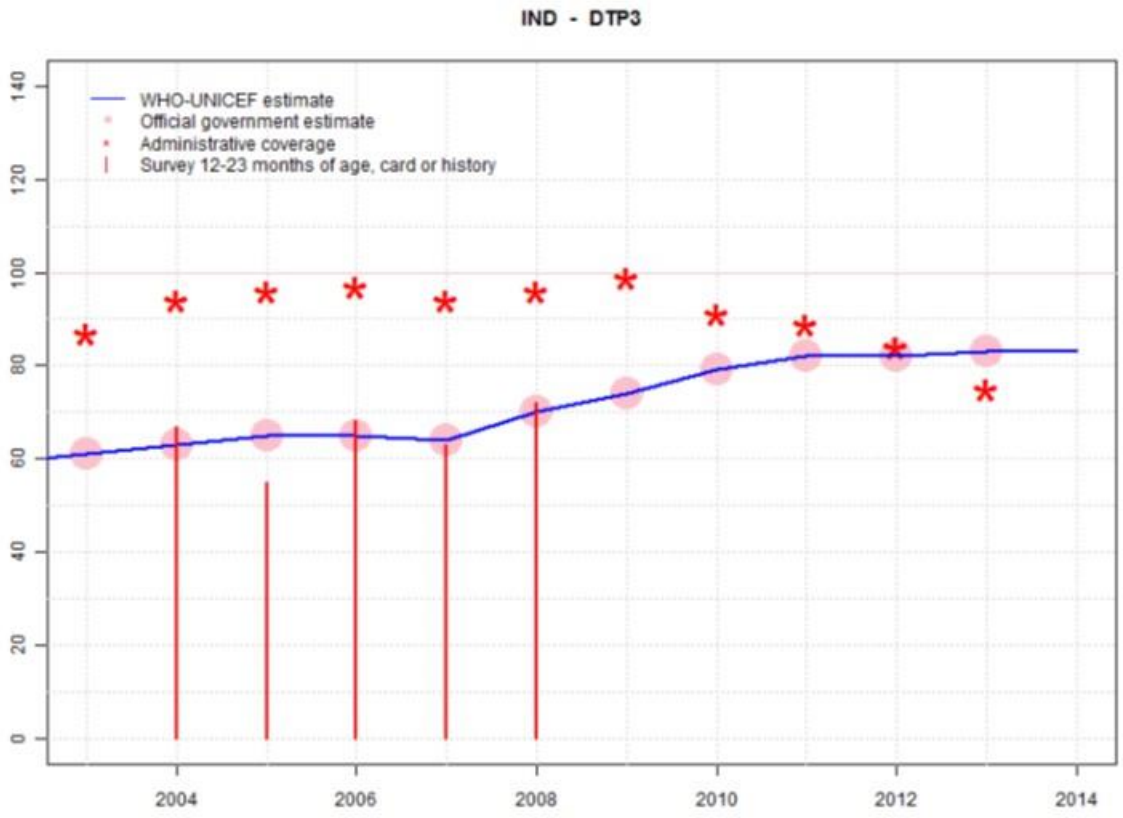
MoHFW is committed to improve the coverage of the UIP across the range of vaccines through multiple activities. WUENIC 2014 revised Indian coverage rates significantly upward even retroactively since 2009 (DTP3 at 83%, OPV3 82%, MCV1 83%). This estimate, and the corrections made since 2010, were based on extrapolation from data reported by the national government. In 2014, India reported an official country estimate of national DTP3 coverage of 88% which is important progress.

The previous immunization coverage came from the Coverage Estimate Surveys (CES) conducted by UNICEF in 2009 and DTP3 coverage rate has been held constant at 72% since then. The UNICEF led Rapid Survey on Children (RSOC) 2013-2014 shows improvements in coverage rates of the fully immunized child from 61% (CES 2009) to 65%.

DTP3 coverage[3] varies widely within the country, with an evaluated coverage of >85% in the southern states and 60%-65% in the northern Hindi heartland. For example, while DTP3 coverage in the state of Karnataka and Kerala is almost 90%, it is only 60% (source: AHS-2, 2011-12) in Uttar Pradesh (UP).

It is important to note that WUENIC has assigned these estimates a grade of confidence on 1* out of a possible 3*** due to no accepted empirical data. They also continue to strongly recommend a high-quality nationally representative survey to confirm reported levels of coverage. India continues to conduct state-level surveys in high-risk states as well as ongoing coverage monitoring.

[3] Official Country Estimates



To our knowledge, there has not been an objective assessment of data systems and data quality conducted in recent years to systematically diagnose their strengths and weaknesses. A first step would be to better understand current data quality monitoring and improvement efforts led by national and state leaders in India. If an information gap in this area is confirmed, it would be highly useful to conduct an in-depth assessment of the administrative data reporting system and data quality using a methodology and implementation approach agreed by in-country stakeholders. After assessing strengths and weaknesses of the system, a strategic data quality improvement plan should be developed followed by targeted planning and closely monitored implementation.

In 2014-2015, India is implementing the fourth National Family Health Survey (NFHS-4) under the purview of the Ministry of Health and Family Welfare, coordinated by the International Institute for Population Sciences, Mumbai, and implemented by a group of survey organizations and Population Research Centres. Technical assistance for NFHS-4 will again be provided by ICF International, USA with the major financial support from the United States Agency for International Development.

The cMYP notes that there are significant inequities in vaccination coverage in different states based on various factors related to the individual (gender, birth order), family (residence, wealth, education), demography (religion, caste) and society (health care access, literacy level) and that there is a clear gender coverage differential, as reported by different surveys. 13% of the children in the poorest quintile receive no immunisation whereas this is only 2% in the richest quintile. The reasons why children are missed (no or partial immunization) are to

32% because of awareness and information gaps and to 30% because of AEFI apprehension.[4] This underscores the importance of demand side interventions.

The difference in coverage by gender for various antigens is according to the CES 2009 in the range of 1% (e.g. OPV3: (Male: 70.2%; Female: 70.7%); fully Immunized (Male: 61.9% and Female: 59.9%)).

One of the key objectives of the UIP is the improvement of coverage rates through interventions on both the supply side for equitable and efficient immunization services (e.g. cold chain and vaccine logistics management, human resources, health management information systems) as well as on the demand side (to reduce barriers to access through advocacy, education and social mobilization). Capacity building for evidence-based policy decisions (M&E systems, VPD surveillance, support for NTAGI) and accountable management of health services will contribute to these objectives.

With multiple new vaccines likely to be introduced in routine immunization schedule (IPV, rubella vaccine, rotavirus vaccine, PCV) it is essential to step up immunization coverage through health systems strengthening to ensure the high impact of these vaccines and to reduce other vaccine preventable diseases covered by traditional vaccines and the scaled-up pentavalent programme. There are other gains from RI strengthening such as sustaining polio eradication and maternal and neonatal tetanus elimination, supporting the polio end game strategy and achieving Measles elimination/Rubella control by 2020 by 2015.

The coverage & equity challenges are under the leadership of MoHFW mainly addressed by the Gavi HSS grant and the in April 2015 launched Mission Indradhanush ("Rainbow").

3.1.2. NVS renewal request / Future plans and priorities

There are no renewal decision to be taken for the penta (US$ 265m fully approved) and IPV programme (12 months support amounting to US$ 30.6m, fully approved).

India has applied in January 2015 for MR support for a wide age range campaign with an originally planned start in July 2015. At the time of the application India did not meet Gavi's measles first-dose coverage criteria. Recent revisions to India's 2010-13 measles SIA administrative coverage information with coverage rates higher than 90% have become available and MCV1 coverage is at 83% (WUENIC 2014).

MR support may be considered in the context of the Gavi India strategy 2016-2021 as part of a comprehensive vaccine portfolio incl. Rota and PCV for which NTAGI already recommended introductions

The details for potential vaccine introductions in the coming years are elaborated in the strategy paper presented to the PPC for the October meeting.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

The Gavi HSS grant (US$ 107 million) will be implemented from 2014-2016 and focuses on 12 states and 127 underperforming districts which partially overlap with Mission Indradhanush in 80 districts. The components of the programme are addressing the main causes of coverage and equity deficits of the immunisation system.

[4] Routine immunization house-to-house data 2014

MoHFW has demonstrated leadership and ownership for this support, which underscores the positive developments for immunization in India.

The outcome indicator in the Performance Framework of the HSS grant affected by all 5 objectives (see below) are the increase of coverage in the 12 priority states with the target that FIC coverage improves from 61% (2009) to 80% (2016) and DTP3 from 72% (2009) to 85% (2016).

The objectives of the HSS grant are:

Objective 1: Strengthen cold chain management in poor performing states through improved human resources capacity, institutional strengthening and supporting supervision (led by UNICEF)

Objective 2: Design and implement an eVIN (electronics Vaccine Intelligence Network) that will enable real time information on cold chain temperatures and vaccine stocks and flows (led by UNDP)

Objective 3: Increase demand for RI through a national Behavioral Change and Communication (BCC) strategy, develop, broadcast and communicate immunisation messages (led by UNICEF)

Objective 4: Strengthen the evidence base for improved policy-making (at all levels) on programmatic areas through a well developed and implemented national M&E plan and research framework (led by UNDP)

Objective 5: Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery and VPD surveillance in 8 priority states (Led by WHO)

Achievements to be highlighted in the reporting period under the 5 objectives are

- Objective 1:
  - establishment of the National Cold Chain Vaccine Management Resource Center (NCCVMRC) in Delhi and strengthening of the National Cold Chain Training Center (NCCTC) in Pune and good utilization of the facilities.
  - finalization of the comprehensive EVM Cold Chain Assessment 2014 and the development of 4 EVM assessments and improvements plans in Assam, Bihar, Odisha and Rajasthan
  - nationwide roll-out of the NCC-MIS and various trainings and improvements in supervision for cold chain points.

- Objective 2:
  - procurement process for all the three components of the eVIN system has been completed and the system is being rolled-out in 20 Districts across Uttar Pradesh, Madhya Pradesh and Rajasthan.

- Objective 3:
  - Seven states have developed and two states are under endorsement of state-specific, evidence-based, and integrated communication strategy for RI and operational plans using a consultative process with state and district programme managers, including state specific development partners.
  - Furthermore, more than 1000 staff from NGOs, CBOs, and Women Federation were trained in communication skills.
  - Immunization messages through mass media, mid media, new media and IPC were developed and broadcasted at a large scale. The monitoring and evaluation for communication through media analysis and other quantitative and qualitative

assessments was carried out and showed a 20% increase to 59% in positive media reporting about immunization.

- Objective 4:
  - the draft ''National M&E Plan for immunization'' has been developed and is currently being reviewed by key partners.
  - INCHIS (Integrated Child Health and Immuni)zation Surveillance has been integrated with “Mission Indradhanush”. The baseline survey called ‘National Immunization Coverage Evaluation (NICE)’ was conducted during April-May 2015 and NICE-Round 2 is currently being fielded (September-October 2015), across 12 states of India.
  - UNDP teams monitored nearly 25% of Mission Indradhanush districts as National Monitors and gave regular feedback for immediate corrective actions.

- Objective 5:
  - WHO India NPSP developed and disseminated guidelines for tagging high-risk areas (HRAs) in routine immunization (RI) micro-plans to all states. WHO India NPSP field medical officers facilitated and monitored the tagging of identified HRAs on a regular basis. Based on the monitoring findings, 97% of the identified HRAs were tagged to RI session sites in 8 GAVI states between Jul’14 and August’15. In addition, 94% of the monitored HRAs were found receiving RI services. The remaining HRAs need to be included in RI micro-plans across the country.
  - WHO India NPSP has been engaged at a large scale in capacity building of government officials, medical officers and frontline workers through revised training materials and info-kits on routine immunization.
  - WHO India NPSP expanded routine immunization monitoring for routine immunization sessions and community monitoring to 24 states, including the polio priority states of Bihar, Jharkhand, Uttar Pradesh and West Bengal and WHO India NPSP conducted intensive monitoring of 201 high-focus districts during four rounds of Mission Indradhanush.
  - WHO India NPSP conducted VPD cum AFP surveillance reviews in Nagaland and Punjab and a VPD laboratory network, comprising seven laboratories across the country with a reference laboratory, has been established by providing support for system strengthening, capacity building and logistics.

Challenges encountered specifically in the areas of planning, monitoring and training are:

- Variable quality of routine immunization micro-plans in the country. The learning from polio has shown that quality of micro-plans is an important determinant of the programme reach for service delivery. Strengthened micro-plans will address the remaining coverage and equity issues.
- Concurrent monitoring for routine immunization supported by WHO is in place in 24 out of the 36 states and union territories. More than 250,000 sessions are being monitored annually in the country by WHO. This generates huge, valuable data that requires quick processing to retain its utility. The current paper based system of collection, compilation, analysis and feedback of data is time consuming.
- Routine immunization data available from HMIS, various surveys and concurrent monitoring led by WHO is shared regularly with the national government and feedback as well as suggested corrective actions on most critical activities is regularly shared with state governments. However, comprehensive annual reviews with all states will not only allow sharing of all available information, but also allow peer to peer learning, as some states have already implemented innovative strategies to overcome challenges that are being confronted by many other states.
- WHO Country Office for India had conducted a techno-managerial training for immunization managers from all states in December 2012. Since then, many officials have been changed

due to transfers, superannuation etc. The new immunization managers at state and district level are often appointed from different backgrounds and may not be conversant with the current techno-managerial issues. There is currently no mechanism of induction training for these officers to better manage the routine immunization programme.

India HSS grant M&E

India has a finalized HSS M&E framework and this will be crucial in helping to establish and finalise India's grant performance framework (to be developed in Q4 2015). Since the beginning of the grant, India provides quarterly progress reports to Gavi that include updates on activity implementation, challenges faced in implementation and reasons for any delays. They complement this programmatic report with a quarterly financial report that details cash utilisation over that period.

This quarterly reporting (compiled by all three HSS grant recipients – UNDP, UNICEF and WHO) is of satisfactory quality and provides the Secretariat a solid understanding of progress and risks for grant monitoring and management purposes. However, the updating and reporting on progress to date against the intermediate results and outcome indicators included in India's finalised HSS M&E framework is essential and has not happened.

Overall, grant implementation appears to be on track with the exception of those activities under Objective 2 and 4, particularly those relating to new software development for cold chain management (eVIN). Related tenders had to be repeated because of the delays for signing the PFA and non-availability of 2015 funding.

It is now necessary to advance preparations for the mid-term evaluation of this grant. The mid-term evaluation in Q4 2015 will guide the implementation in the last year of the grant and start identifying areas for further support. The ToRs for the evaluation are currently under review by MoHFW and partners.

UNDP reports that the "National M&E Plan for Immunisation" they were responsible for leading the development of has been drafted and is now under review. It is necessary to confirm the finalisation and start the implementation of this plan.

Civil Society Organizations

Civil Society Organizations (CSOs) offer a wide range of experience and knowledge essential to the immunization programme. They can provide insight into gaps in health service delivery and identify practical and political challenges that must be overcome to improve the programme.

GAVI support to Civil Society Organizations (CSOs) has resulted in launch of Alliance for immunization (Aii) at the national level in December 2013 and now has a network of about 180 CSOs. The Catholic Health Association of India (CHAI) facilitates the platform. A National Steering Committee has been formed and four state chapters have been established in Bihar, Jharkahand, Uttar Pradesh and Rajasthan. The Aii has conducted capacity building programs and effective media communication. The Alliance was also represented in pentavalent post introduction evaluation and it is a member of the State Task Force on immunization. It is currently supporting Mission Indradhanush. The CSO platform Aii will continue to partner with the government both at the state and national levels, working towards community ownership of routine immunization.

However, Aii and CSOs are currently not directly supported by HSS grant funds which limits their activities and integration into the implementation of HSS activities. In the context of the national Polio programme CSOs are engaged through social mobilization networks supported by UNICEF and WHO.

3.2.2. Strategic focus of HSS grant

As elaborated in the pre-ceeding section the HSS grant in India is focusing on coverage and equity impact in underperforming states/ regions and addresses main deficits of the health system to deliver better results for immunization. The HHS grant conceptually influenced and supplemented Government's Mission Indradhanush, which showed good results in the first 4 months after its launch in April, with 2 million fully immunised children.

As mentioned above, the mid-term evaluation will guide the implementation in the last year of the grant and develop lessons learnt.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

The third tranche for the HSS grant (approximately US$ 39m) should be released in the beginning of 2016. The approval is requested.

MoHFW has informed the Secretariat about possible re-allocations from savings in the budget under Objective 2 of the grant to Objective 4 for the purchase of cold chain equipment. The re-allocated amounts are below the 15% threshold or US$ 10m and this decision can be followed-up between MoHFW, Gavi Secretariat and partners. Further information is awaited from MoHFW to the Secretariat.

3.3. Graduation plan implementation *(if relevant)*

Not relevant.

3.4. Financial management of all cash grants

The HSS grant funds are disbursed to the implementing partners WHO, UNICEF and UNDP. Financial reporting of fund utilization is integrated into the quarterly reporting on the grant by MoHFW and partners. The UN agencies provide audited statements annually after conclusion of the financial reporting period. There are currently no outstanding audit issues.

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
Pentavalent programme: Continue regular dialogue and progress updates on the roll-out to the remaining 16 states and monitor dose shipment schedules and requirements. MoHFW to inform Gavi about national procurement of penta vaccine from FY 2016/17 onwards. **IPV programme:** Continue dialogue about the vaccine dose requirements for the first 12 months of support. MoHFW to inform Gavi and GPEI about national procurement of IPV vaccine after conclusion of Gavi/ GPEI support	MoHFW, WHO, UNICEF, Secretariat.	Ongoing	None
HSS programme: • Finalize ToR for mid-term evaluation in Q4 2015 • Update Performance Framework of the grant • "National M&E Plan for Immunisation" has been drafted and is now under review. It is necessary to confirm the finalisation and start the implementation of this plan.	MoHFW, WHO, UNICEF, Secretariat	End of October	None.
IAG (Immunization Action Group): Strengthen IAG by pre-dictable scheduling and agenda setting. 3-4 meetings annually should be envisaged**.**	MoHFW	Ongoing	None.

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

The UIP is mainly supported by WHO and UNICEF and the details are included in the section on the HSS grant. Furthermore, MoHFW is supported by the Immunisation Technical Support Unit (ITSU) in various areas (e.g. M&E, NTAGI Secretariat, Cold Chain equipment and vaccine logistics, communication and advocacy, new vaccine introductions) which is funded by the Bill & Melinda Gates Foundation.

4.2 Future needs

MoHFW has with the cooperation of partners developed a detailed and comprehensive needs analysis which identifies 19 areas of prioritized TA support. Currently no provider has been defined and no costing of activities has been carried out.

On this basis the dialogue, which is at the earliest stage, needs to continue swiftly to narrow down the support which is suitable to be financed through the PEF.

The table with the TA needs is included as an annex as it is very comprehensive.

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

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 Development Partners are taken by mode of India Immunization partner's meetings, National Technical Advisory Group of Immunization (NTAGI), Immunization Action Group (IAG), Technical working groups, during the national level review meetings, and at other appropriate fora. There were 8 meetings in the APR reporting period (1 – NTAGI, 4 -STSC, 2 – IAG, 1- EPC (Empowered Programme Committee National Health Mission+). Additionally an IAG meeting was held in July 2015 and the NTAGI met in August.
Issues raised during debrief of joint appraisal findings to national coordination mechanism: As the JA was done remotely there was no formal debrief with IAG.
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager: None.

6. ANNEXES

- **Annex A. Key data** (included in the Cover Note)

- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Topic	Action Point	Responsible	Timeline	Status
HSS	Inform GAVI Secretariat about IAG endorsement of HSS grant objectives and budget re-alignment in accordance with GAVI Alliance guidelines for re-programming submission for HSS grants (2013).	MoHFW	30 days of receipt of Information Letter	Done
Action Points as defined during the JA	1) Section 3 (Governance) regarding the strengthening of the IAG 2) Section 6 (Data Quality) regarding the Monitoring and Evaluation follow-up and evaluation of the HSS grant 3) Section 10 (Financial Management) regarding the negotiations of the PFA and the strengthening of programmatic and financial reporting of the HSS grant	MoHFW, GAVI Secretariat, partners	With immediate effect and ongoing	1) IAG needs further strengthening and institutionalization 2) Progress in accordance with the implementation of the HSS grant. Requires regular monitoring. 3) PFA signed in July 2015 with delays 4) Programmatic and financial reporting of satisfactory quality.

- **Annex C. Description of joint appraisal process**
  - See Section 1.4 of the JA report.

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date			October 2013				
1.2 Date of reprogramming approved by IRC, if any			-				
1.3 Total grant amount (US$)			US$ 107 million				
1.4 Grant duration			2014-2016				
1.5 Implementation year			month/year – month/year				
(US$ in million)	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**

1.6 Grant approved as per Decision Letter	US$ 27m	US$ 41m					
1.7 Disbursement of tranches	US$ 27m (12/2013)		US$ 41m (7/2015)				
1.8 Annual expenditure		US 36.4m until 6/2015					

1.9 Delays in implementation (yes/no), with reasons	Inception phase until 6/2014 with re-alignement of objectives. Delays under Objective 2 (UNDP) led because of late signature of PFA in July 2015 and delayed disbursement of 2nd tranche of funding.
1.10 Previous HSS grants (duration and amount approved)	n.a.

1.11 List HSS grant objectives

Objective 1: Strengthen cold chain management in poor performing states through improved human resources capacity, institutional strengthening and supporting supervision (led by UNICEF)

Objective 2: Design and implement an eVIN (electronics Vaccine Intelligence Network) that will enable real time information on cold chain temperatures and vaccine stocks and flows (led by UNDP)

Objective 3: Increase demand for RI through a national Behavioral Change and Communication (BCC) strategy, develop, broadcast and communicate immunisation messages (led by UNICEF)

Objective 4: Strengthen the evidence base for improved policy-making (at all levels) on programmatic areas through a well developed and implemented national M&E plan and research framework (led by UNDP)

Objective 5: Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery and VPD surveillance in 8 priority states (Led by WHO)

1.12 Amount and scope of reprogramming (if relevant)

- **Annex E**
    - **Needs assessment for Technical Assistance for the Indian UIP**