**Budget Clarifications**

**The detail budget does still contain 5% of Technical Assistance for UNDP, 12% of Technical Assistance for UNICEF while the amount of WHO operational cost (30% of cost of 196 field offices) has increased to 1.84 million (= 7%, up from $  1.59 million).**

**While a short explanation has been added on how many positions will be funded with the TA amount of UNDP and UNICEF, no detailed calculation has been provided**

**Detail response and justification on budget related to technical assistance and operational cost by lead implementers and difference between these costs and program support costs are:**

|  |  |  |
| --- | --- | --- |
| **UNDP response on 5% technical assistance** | **UNICEF response on 12% technical assistance** | **WHO response on operational costs** |
| To implement any project especially the one of this size and within a very tight timeline, UNDP need to incur both direct and indirect costs. Please find break-up of the GMS costs and the Technical Assistance (or Direct Project Costs (DPC).**GMS (Charged at 7%)** Encompasses costs incurred in providing general management and oversight functions, including:1. General oversight and monitoring2. Thematic and general technical backstopping 3. Systems, IT infrastructure, branding, knowledge transfer, etc.4. Alignment of results with national priorities in the Country Programme Document and the Country Programme Action Plan and Projects5. Quality control process to ensure that individual project documents are aligned to the basic principles of the agreement between UNDP and the Host Government 6. Monitoring the progress in capacity development of our national partners and adapting  programme arrangements accordingly 7. Accountability to donors, including national entities as donors, for the standards, design and  accuracy of reporting 8. Developing and issuing appropriate audit guidelines for nationally implemented  projects Monitoring compliance with the guidelines and monitoring of corrective actions based on audit observations 9. Analysis of audit reports and taking appropriate actions to address the risks reflected in the audit report, i.e. change in disbursement modality, change in assurance procedures, suspension of the programme, suspension of the projects, etc. **DPC (Technical Assistance) (Being charged at 5%) These costs include:** 1. Policy-advisory, technical and implementation essential to deliver development results2. Costs incurred to support project implementation byOperations units, including services related to a. finance, procurement b. human resourcesc. issuance of contractsd. security e. travel f. assets g. general services and informationh. communications technologyThe detailed breakup of the DPC is provided in the attached excel sheet for reference. As per attached document the DPC amounts to USD 2,154,384. However, for the purpose of this grant these costs have been limited to 5% only. | The7 per cent recovery cost aims at covering indirect costs incurred by UNICEF Head Quarters. The 12 per cent cost for technical assistance is part of the consolidated budget in the proposal and is separate from the 7 per cent recovery cost of UNICEF HQ. Contrary to other proposals that are heavy in supply component, GAVI HSS proposal is heavy in capacity building and health system strengthening components. Thus the 12 per cent cost for technical assistance is in line with requirements of the proposal's activities. **UNICEF has further reduced this 12% technical assistance to 5%** by reducing the time of Immunization health specialists to 60% instead of 100%. Rest of their time will be used for other UNICEF’s project. This change is reflected in revised GAVI HSS budget attached with this document | WHO’s definition of **Programme Support Costs** is: “*All costs that are incurred by the Organization as a function and in support of its activities, projects and programmes, and which cannot be traced unequivocally to specific activities, projects or programmes. These costs typically include service and administrative units, as well as their related system and operating costs. Usually referred to as Programme Support Costs, or PSC, these costs must be recovered and included in all donor proposals and negotiations."*Programme Support Costs (7%) are supposed to cover cost of employing human resources working commonly (in WCO, RO, HQ) on supporting all projects, budget and operational planning, central financial functions relating to income recording, creation/modification of awards, contribution management, financial reporting, preparation of financial statements and accounts, space rentals/utilities/other admin expenses for WHO offices etc that can-not be directly associated with any particular project.With reference to **Operational Costs of $1.35 million** that have been budgeted for GAVI, the breakdown is provided in attached excel sheet.WHO polio staff will be spending 30% of their time on the GAVI grant activity; however, only 22% of all related costs like vehicle running cost, electricity, communication cost, repair and maintenance, etc. are proposed as operational costs (amounting to 5% of program activity cost).  In this context, though administrative in nature, these costs clearly constitute “Direct Costs” for the project per-se. **The operational costs constitute only 5% of the total programmatic activity cost** for WHOAbove clarifies the concept of Programme Support Costs (indirect costs) as different from the directly budgeted operational costs (which are more in the nature of direct project costs). |

**ToRs of the Immunisation Action Group**

**Background:**

The Partners Forum, formed in 2007, meets quarterly and has representation from a wide range of experts in areas of immunization, program management and health systems in India, and includes members from the MoHFW, ITSU, UNICEF, WHO and other partners. The main purpose of the Forum is to coordinate activities to strengthen RI. The Partners Forum met in August 2012 to discuss the draft GAVI HSS proposal, and Partners were provided an opportunity to provide feedback/comments on the draft.

In October 2011, MoHFW constituted a national level IAG to help intensify RI program. Immunization Action Group has been constituted under the chairpersonship of Joint Secretary RCH. Group is Co-chaired by Deputy Commissioner Child Health & Immunization. The purpose of this group is to periodically advise the immunization division regarding ways to improve the coverage and to provide technical suggestions for taking up new initiatives.

The Partners Forum and the IAG are equivalent to Health Sector Coordination Committee (HSCC) in India.

**Term of reference:**

IAG is a forum to

* Guide Immunization division regarding ways to improve immunization coverage
* Provide technical support to immunization division, MoHFW in strengthening UIP
* Provide suggestions on taking new initiatives to improve immunization program efforts
* Understand thematic and geographic strength & mandate of each partner organization in the field of immunization
* Coordinate between partner agencies for synergistic actions, joint assessments and program review
* Share best practices, learning experiences from states
* Review progress of implementation of immunization program including newer vaccines, campaigns and recent initiatives
* Share GoI priorities and areas of additional support required.
* Present action taken report in follow up meeting

**Membership:**

1. MoHFW
2. ITSU/PHFI
3. WHO
4. UNICEF
5. UNDP
6. USAID/MCHIP
7. INCLEN
8. BMGF
9. ICMR
10. NII
11. NCDC
12. Deptt. Of PSM MAMC
13. IAP
14. Deptt. of Biotechnology
15. Special invitee and/or subject experts

**Role of IAG in GAVI HSS Proposal**

The IAG, chaired by Joint Secretary Reproductive & Child Health, will meet every quarter to review the progress of HSS Grant, discuss challenges and to take corrective action.

IAG with HSS secretarial support will be responsible for reviewing the reports submitted by lead implementers on financial and physical progress of the HSS grant through quarterly meetings

The ministry, lead implementers and state health departments have been working with CSOs in the health sector. Key CSOs will be identified and CSOs will be included in the IAG as well as state and district coordination groups, and the planning and implementation of activities.

Key state managers will also be included as members in IAG at national level and will be invited to the meetings to review and share feedback on HSS grant.

**M & E Framework:**

Further clarification is required on:

**Equity indicators: Disaggregated coverage data by sex of the child is noted but we also require equity by geography and wealth status.**

HSS proposal emphasize to promote equity in immunization program. HSS proposal will be an opportunity to address geographical, wealth and gender disparities in immunization program to reach every last child. Proposal is focusing on 12 high priority states with low immunization coverage in the country. Further geographical disparities will be addressed by focusing on 127 high priority districts in these 12 states out of total 184 high priority districts in the country. Whole proposal is aim on focusing geographical and other disparities and M & Framework is already addressing this. Country will also focus on district wise immunization coverage for these 127 high priority districts of 12 high focus states. Baseline for this will be DLHS 3 data and increase in coverage for these districts will be in line with increase in states coverage. (127 high priority districts list attached with immunization coverage as per DLHS 3)

WHO objective 5 focuses on strengthening RI in 154433 high risk areas which are having low wealth index and also underserved areas for RI services. Improving immunization services in these areas will further reduced geographical and wealth inequity in immunization program. M & E indicators for objective 5 are already addressing this.

Wealth Index baseline for 12 high focus states is attached with this document along with baseline figure from CES 09. HSS grant will focus on reducing this disparity in these high focus states

**In the response sent by India I do not see any further clarification on the evaluation.  I paste below the question we raised previously for reference:**

**What is being proposed for the evaluation of this grant overall? (see IRC recommendation) – are you still planning for a baseline, mid-term and end of grant evaluation? Who will conduct this?**

Baseline for HSS M & E indicators has already been shared in performance framework.

For immunization coverage related indicators CES 09 will be baseline for state and DLHS 3 for district.

Midline and end line for HSS grant will be a subset of overall National M & E plan. National M & E plan has been proposed in the HSS grant budget and within over all envelop of $ 107 million, an allocation of USD 4.5 million ($ 1.5 million from each implementing partner) has been proposed.

National M & E plan proposed a yearly evaluation survey for routine immunization, focusing on outcome and impact indicators of all the components of RI including HSS grant indicators. This can be done through external agency in line with NFHS and DLHS surveys.

Individual activity level evaluations will be part of activity budget in each partner budget sheet and will be carried out either through lead implementers M & E system or external organizations as per individual agencies activity plans