GAVI Alliance

Annual Progress Report 2014

Submitted by

The Government of

India

Reporting on year: **2014**
Requesting for support year: **2016**
Date of submission: **03/07/2015**

Deadline for submission: 27/05/2015

Please submit the APR 2014 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavi.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: **2014**

Requesting for support year: **2016**

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	2015

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	2016	2016

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2014	Request for Approval of	Eligible For 2014 ISS reward
HSS	Yes	next tranche of HSS Grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2013 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 High Level Review Panel (HLRP) 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	**Name**	NA
Date		**Date**	
Signature		**Signature**	

<u>This report has been compiled by</u> (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), Ministry of Health & Family Welfare, Govt of India	+918800495771	pradeephaldar@yahoo.co.in
Dr Ambujam Nair Kapoor	Senior Advisor (ITSU)	+919945395366	ambujam.kapoor@phfi.org

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.Arun Thapa	WHO Country office		

Mr.Louis George Arsenault	UNICEF		
Mr.Jaco Cilliers	UNDP country office		

ICC may wish to send informal comments to: apr@gavi.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), 2015 , 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
Dr.Arun Thapa	WHO Country office		
Mr. Louis George Arsenault	UNICEF		
Mr. Jaco Cilliers	UNDP Country office		

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

India is not reporting on CSO (Type A & B) fund utilisation in 2015

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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.

Please also note that if the country applies the WHO multi-dose vial policy for IPV, the maximum indicative wastage rates are 5%, 15% and 20% for the 1-dose, 5-dose and 10-dose presentations respectively.

Number	Achievements as per JRF		Targets (preferred presentation)			
	2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation
Total births	18,300,000	5,022,917	18,300,000	28,338,000	27,394,000	27,687,000
Total infants' deaths	768,600	200,917	768,600	1,133,520	1,287,518	1,116,000
Total surviving infants	17531400	4,822,000	17,531,400	27,204,480	26,106,482	26,571,000
Total pregnant women	20,130,000	29,718,200	20,130,000	29,718,200	31,503,100	30,458,000
Number of infants vaccinated (to be vaccinated) with BCG	18,300,000	24,113,040	18,300,000	24,211,987	27,394,000	27,687,000
BCG coverage*[1]*	100 %	480 %	100 %	85 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with OPV3	17,531,400	22,521,277	17,531,400	23,667,898	26,106,482	26,571,000
OPV3 coverage*[2]*	100 %	467 %	100 %	87 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*	17,531,400	18,639,338	17,531,400	0	26,106,482	26,571,000
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*	17,531,400	18,520,018	17,531,400	0	26,106,482	26,571,000
DTP3 coverage*[2]*	100 %	384 %	100 %	0 %	100 %	100 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP	17,531,400	40	17,531,400	40	26,106,482	10
Wastage*[5]* factor in base-year and planned thereafter for DTP	0.00	1.67	0.00	1.67	0.00	1.11
Number of infants vaccinated (to	7,747,748	5,225,529	23,857,281	23,939,942	26,106,482	26,571,000

be vaccinated) with 1st dose of DTP-HepB-Hib						
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	7,747,743	4,240,906	22,450,018	23,939,942	26,106,482	26,571,000
DTP-HepB-Hib coverage*[2]*	44 %	88 %	128 %	88 %	100 %	100 %
Wastage*[5]* rate in base-year and planned thereafter (%) *[6]*	15	21	15	15	15	15
Wastage*[5]* factor in base-year and planned thereafter (%)	1.18	1.27	1.18	1.18	1.18	1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0 %	0 %	0 %	25 %	0 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	17,531,400	22,816,640	17,531,400	23,939,942	26,106,482	26,571,000
Measles coverage*[2]*	100 %	473 %	100 %	88 %	100 %	100 %
Pregnant women vaccinated with TT+	20,130,000	17,537,395	20,130,000	20,130,000	26,106,482	30,458,000
TT+ coverage*[7]*	100 %	59 %	100 %	68 %	83 %	100 %
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	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	1 %	0 %	0 %	0 %	0 %

[1] Number of infants vaccinated out of total births

[2] Number of infants vaccinated out of total surviving infants

[3] Indicate total number of children vaccinated with either DTP alone or combined

[4] Please make sure that the DTP3 cells are correctly populated

[5] 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.

[6] 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.

[7] Number of pregnant women vaccinated with TT+ out of total pregnant women

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 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2014.** The numbers for 2015 - 2015 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 targetbeneficiaries for the year 2014-15 represent the annual birth cohort of all 19states

Including 11 which wereproposed to introduce pentavalent vaccine in 2014. These target

beneficiaries do not include any proposed scale upbeyond 19 states of India.

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

Thetarget beneficiaries for the year 2014-15 represent the surviving infants ofall 19 states including

11 which were proposed to introduce pentavalentvaccine in 2014. These target beneficiaries do not include any proposed scaleup beyond 19 states of India.

- 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.** For IPV, supporting documentation must also be provided as an attachment(s) to the APR to justify ANY changes in target population.

Not applicable

- 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: 1. 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.

2. Note: For Table in section 4 :
*Denominator for BCG & OPV3 coverage is total surviving infants for all states(=25928000)

**Denominator for DPT3 coverage is total surviving infants in non-pentavalent states(=21106000)

***Denominato rfor DPT-HepB-Hib 3rd dose coverage is total surviving infants in pentavalent states (=4822000)

****Denominator for TT+ coverage in pregnant women is total pregnant women for all states (29718200)

5.2. Monitoring the Implementation of GAVI Gender Policy

5.2.1. 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%

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

Thedifference in coverage by gender in various antigens is evaluated in theCoverage Evaluation Surveys. The last Coverage Evaluation Survey of 2009 hasreported that the differences in coverage with various antigens were in therange of 1%. As per CES-2009; the coverage with various antigens in male andfemale 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%).

Theimmunization program in India aims to provide vaccines to all childrenirrespective of gender. Improving programme service delivery forequitable and efficient immunization services by all districts is the first keyobjective of the UIP strategic plan framework for 2013-2017 as per the cMYP.

5.2.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Not selected**

5.2.4. 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/)

To address the inequities in immunization(including gender inequity), Government of India has been conducting'Intensification of Routine immunization' weeks for the last two years in areaswith poor immunization coverage. The programme makes special efforts to reachthe unreached and improve immunization through intensification of routineimmunization; four Special Immunization Weeks were carried out in low coverageareas and in high risk pockets throughwhich 8.3 million children under two years of age were covered in 2014-15. In addition, MissionIndradhanush was launched in Dec. 2014, the objective of which is to ensurehigh coverage of children with all vaccines in the entire country with a highfocus on the 201 identified districts.

5.3. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.3a** 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$ = 63.2	Enter the rate only; Please do not enter local currency name

Table 5.3a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2014	Source of funding						
		Country	GAVI	UNICEF	WHO	NA	NA	NA
Traditional Vaccines*	42,667,299	42,667,299	0	0	0	0	0	0
New and underused Vaccines**	24,331,593	0	24,331,593	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	12,124,664	12,124,664	0	0	0	0	0	0
Cold Chain equipment	966,619	966,619	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	29,941,465	29,941,465	0	0	0	0	0	0
Grant -in-aid to States In addition, for Traditional vaccines the amount also includes @ includes Operational cost (US$ 29890823) released to the states for strengthening of RI from RCH flexible pool of MOHFW		329,062	0	0	0	0	0	0
Total Expenditures for Immunisation	110,031,640							
Total Government Health		86,029,109	24,331,593	0	0	0	0	0

Traditional vaccines: BCG, DTP, OPV, 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

5.4. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2014? **8**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2015 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 5.3 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 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 as indicated above (1 – NTAGI, 4 -STSC, 2 – IAG, 1- EPC)

Empowered Programme Committee Meeting of the National Health Mission (5thNovember 2014)

Following NTAGI's recommendation, 3 new vaccines were forwarded by EPC for MSG approval:

- Measles Rubella Vaccine was recommended for MSG approval. MR vaccine will be introduced first as a phase wise campaign in the age group 9 months to 15 years of age (costing Rs. 1556 crores) and then as a two dose schedule in Routine Immunization (costing Rs. 50 crores per annum).
- Rotavirus vaccine will be introduced initially with 10 million doses (costing Rs 60 crores). Nationwide wide scale-up would cost Rs. 614 crores per annum.
- Inactivated Polio Vaccine will be introduced in last quarter of 2015, as a part of Polio end game strategy. A proposal to support this introduction has been submitted to GAVI.

IAG Meeting (20th June 2014)

- The phased scale-up of pentavalent vaccine is planned keeping in mind the lessons learnt and the favorable report of the post introduction evaluation of the pentavalent vaccine.
- The favorable wastage rate of 10% against the targeted 15% was appreciated.

Project Management Cell to form a common format and consolidated report for all partners to be submitted to GAVI in it.

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

If Yes, which ones?

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

5.5. Priority actions in 2015 to 2016

What are the country's main objectives and priority actions for its EPI programme for 2015 to 2016

- The scale up of pentavalent vaccine in the remaining 16 states would be closely monitored and states would be provided regular support and technical assistance for smooth inclusion of vaccine in state programs.
- IPV will be introduced in 2015 as part of post -eradication strategy for Polio, preceding switch from tOPV to bOPV.
- Measles Rubella campaign will begin in 2015-16 and will be conducted in phases.
- Country will implement the GAVI HSS project with a focus on innovative technology such as eVIN to strengthen vaccine logistic and cold chain mechanisms in 2015-16.
- 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.
- Mission Indradhanush will cover 201 districts in 28 states across the country through four special week long drives in 2015-16. It will aim to increase full immunization coverage to 90% by 2020.
- The focus on the identification of missed areas for RI will be retained and improvement in RI micro-plans followed by attention on regular immunization sessions in those areas will be paid.
- The RI monitoring efforts will be further intensified and scale up to the additional states of India. The efforts and attention will be paid to increase the monitoring by the government staff at various levels.
- States and districts will continue to conduct risk analysis to identify and prioritize high risk blocks, gap analysis to identify bottlenecks in high risk areas, review and update the micro-plans of these areas and strengthen monitoring of session sites and community.
- The immunization program Performance will be reviewed through regular UIP review meetings held at various levels, on timely intervals.

India would continue to conducted Effective VaccineManagement (EVM) assessment in 2015. The findings of EVM assessment would beutilized for preparation of detailed cold chain improvement plan and tostrengthen cold chain and vaccine management in the country.

5.6. 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 2014

Vaccine	Types of syringe used in 2014 routine EPI	Funding sources of 2014
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
IPV	Not applicable	Not applicable

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)

Please explain in 2014 how sharps waste is being disposed of, problems encountered, etc.

Injection safety andwaste management protocols are incorporated into existing routine immunizationguidelines. All health staff dealing with injections including routineimmunization injectable vaccines are regularly trained on these protocols.Information from monitoring of sites is shared with districts and states forappropriate response.

The Hub-cutters are being provided to allvaccinators (ANMs) in UIP in India, which are used for cutting of AD syringesimmediately after the use. The Red and Black plastic bags are being providedfor each session site for segregation and collection of immunization waste. Thesafety pits for immunization waste are being constructed under funding providedthrough National Health Mission (NHM) in India. In addition, a number of states in the country havedeveloped public private partnership for immunization and hospital wastedisposal mechanism.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

India is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.2. Detailed expenditure of ISS funds during the 2014 calendar year

India is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.3. Request for ISS reward

Request for ISS reward achievement in India is not applicable for 2014

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

7.1. Receipt of new & under-used vaccines for 2014 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2014 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2014 vaccinations against approvals for 2014

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

	[A]	[B]	[C]	
Vaccine type	**Total doses for 2014 in Decision Letter**	**Total doses received by 31 December 2014**	**Total doses postponed from previous years and received in 2014**	**Did the country experience any stockouts at any level in 2014?**
DTP-HepB-Hib	31,136,500	26,355,000	1,972,000	No

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? ...)

  Governmentof India has introduced Open Vial Policy in 2013, which has resulted in reducedwastage rates.

  Some states delayed implementation of vaccinationprogram despite having received the vaccines on time, resulting in lowerutilization of the planned vaccination

- 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.

  - Regular review meetings were held with States for proper management of cold chain. It was ensured that States have sufficient numbers of cold chain equipments and staff is well trained to maintain cold chain properly
  - Prior to introduction of Pentavalent vaccines in each state, all categories of staff were trained using operational guide lines for introduction of Pentavalent introduction
  - A national Effective Vaccine Management Assessment was carried out in 2013 which included States where Pentavalent has been introduced. Based on its recommendations standardized stock registered have been provided for all states, National standards in cold chain and vaccine logistics have been drawn up and a National Cold Chain and Vaccine Logistics Action Plan (NCCVLAP) is being drafted in consultation with stakeholders.

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.

7.2. Introduction of a New Vaccine in 2014

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2014, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Nationwide introduction	Yes	01/12/2011
Phased introduction	Yes	01/03/2015
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

When is the Post Introduction Evaluation (PIE) planned? **December 2016**

7.2.2. 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))

India has planned forthe phased introduction of pentavalent vaccine. 2 states have introducedpentavalent vaccine in 2011. A total of 6 additional states of India - Jammu&Kashmir, Gujarat, Goa, Haryana, Karnataka and Puducherry, were scheduledto start pentavalent vaccination by October 2012 but only one state (Haryana)could start vaccination then. By March 2013, the remaining five states alsointroduced the Pentavalent vaccine.

By Oct 2014 a further12 States have introduced the vaccine and by March 2015, the vaccineintroduction will be scaled up to the entire country.

In 2015-16, pentavalent vaccine will be scaled up tothe remaining 16 states.

A Post Introduction Evaluation of pentavalent vaccine was conducted in March 2014 in 6 states and Union Territories (Goa,Gujarat, Haryana, Jammu and Kashmir, Karnataka and Puducherry. A copy ofthe report of the Post Introduction Evaluation (PIE) is attached.

Based onthe findings of post-introduction evaluation (PIE) of pentavalent and seconddose of measlesvaccine state and district preparedness assessment checklists for strengtheningof routineimmunization coverage and pentavalent vaccine introduction were developed. Thesewere used by state and district programme managers to assess the status oftheir preparednessto introduce the new vaccine and identify the key areas that requirestrengthening prior tothe introduction. Learning from the findings all states introducing Pentavalentin 2014 and2015 organized state and district level launches. In addition to trainings of medicalofficer and vaccinators, data handlers and cold chain handlers were alsotrained. Manystates and districts organized IEC workshops for mobilization of the communityand generatingawareness.

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**

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? **Yes**

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:

Results of Surveillance /Special studies

Laboratory data fromIndian Rotavirus Surveillance Network: Approximately 7285 samples were tested acrossthe country and salient findings were: Rotavirus accounted for nearly 40% of all diarrhealhospitalizations. Rotavirus diarrhea was reported most frequently fromhospitals was children aged6-24 months. There was clear seasonality in Delhi, Kolkata and Pune with infections peaking inwinters, but not in the Vellore and Trichy centers. G1, G2 were the most common strains detected. G9 and G12strains were also detected.

Proportion of *S.pneumoniae* isolated in confirmed meningitis cases (by culture method) in different surveillancesites ranges from 4.5% to 7.1%.

Inputs from NTAGI

December 2013 STSC Meeting

The presentations highlighted that the burdenof RD in India is considerable, not just in terms ofmortality, but also in terms of morbidity of diarrheal disease and the possiblelong-term sequelae.

Dependable background rates forintussusception amongst children >5 years of age in India will aid calculation of reliable estimates of increasedrisk (if any) attributable to introduction of RV in India's UIP.

Post-marketing surveillance mechanisms andadverse effects after immunization (AEFI) monitoring will have to be addressed prior to introduction

April 2014 STSC Meeting

Concerns were expressed regarding thepossibility of mixed infections inflating the proportion of diarrhea disease attributable to rotavirus.In this regard, it was clarified that:

a) Asymptomatic infections of rotavirus tend tobe associated with very specific G&P genotypes (P11 in particular, with G9 or G10). Rotavirusinfections caused by the remainder of genotypes are very likely to be associated with disease.

b) As observed in the GEMS study, whichenrolled healthy children to adjust for asymptomatic carriage of enteric pathogens and accounted formixed infection by calculating an adjusted

attributable fraction, rotavirus was the causative agent in >90% of cases in whichit was found.

c) Data from the CMC Hospital, Vellore indicatesthat <8% of diarrhea episodes were identified as mixed infections.

d) Given the high rates of rotavirus attributabledisease in the GEMS study, rotavirus is clearly the most common cause of dehydrating or moderate to severe gastroenteritisin children in India.

December 2014 STSC Meeting

The need for collation of the availableevidence on pneumococcal burden in India with the objective of determining if possible,population level estimates on the deaths, hospitalizations

and cost of pneumococcal disease in India washighlighted.

7.3. New Vaccine Introduction Grant lump sums 2014

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2014 (A)	0	0
Remaining funds (carry over) from 2013 (B)	0	0
Total funds available in 2014 (C=A+B)	0	0
Total Expenditures in 2014 (D)	0	0
Balance carried over to 2015 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2014 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2014 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

No New Vaccine Introduction Grant has beenreceived. Operational cost for introduction of Pentavalent vaccine in India hasbeen borne by the Government of India. Gavi hasprovided pentavalent vaccine as commodity grant for India for introduction of Pentavalent Vaccine. The Pentavalent Vaccine wasinitially introduced in two states viz. Kerala and Tamil Nadu in December 2011and six more states i.e. Haryana, Goa,Puducherry, Jammu & Kashmir, Gujarat and Karnataka introduced Pentavalentvaccine in year 2012-13 under routine immunization programme. At the beginningof 2014, pentavalentvaccine was being used in these eight states and union territories ofIndia. A total of304 lakh doses of pentavalent vaccine have been administered in eight statessince inception till Jan 2015.

Apost-introduction evaluations (PIE) was conducted in six states and unionterritories to evaluate the impact of new vaccine introduction on the existingimmunization system and services. The PIE provided a detailed and systematicreview of the strengths and weaknesses identified with the introduction ofpentavalent vaccine. Based on key lessons learnt and recommendations from therecently concluded PIE, the Government of India proposed to introducepentavalent vaccine in the remaining states of the country in a phased manner.As part of the scale-up of use of pentavalent vaccine in the country, 12additional states—Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Jharkhand,Madhya Pradesh, Punjab, Rajasthan, Telangana, Uttarakhand and West Bengal—wereidentified by the programme for introduction of the vaccine in 2014-15. Anational workshop was organized to orient the programme managers and policymakers of 12 states on technical and operational issues identified during thePIE which were relevant for the introduction of pentavalent vaccine in thesestates. A preparedness assessment through standardized self-assessmentchecklists was undertaken in these 12 states prior to introduction ofpentavalent vaccine. The data was analyzed and shared for corrective action.The state and district training workshops in these 12 states were supported byWHO India. A total of 270 district immunization officers, 881 medical officers,855 data handlers, 570 cold chain/vaccine handlers and 590 IEC managers weretrained during the state workshops.

Eightof these 12 states have introduced pentavalent vaccine, while three statesnamely Andhra Pradesh, Chhattisgarh, Jharkhand and Telangana are likely tocomplete the preparatory process and introduce the vaccine by March 2015. Atotal of 27.8 million (278 lakh) children have received pentavalent vaccine up toDecember 2014. The Government of India now plans to expand introduction ofpentavalent vaccine in the 16 remaining states in 2015. The Ministry of Health& Family Welfare has directed the states to start assessing

theirpreparedness using the checklist developed by WHO India.

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 2015 onwards

Not applicable

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2014 from the following sources?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ 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		
	Q.4: When do you intend to transfer funds for co-financing in 2016 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Responseto Question 1 to Question 5: The Gavi Alliance new Vaccine Introduction support toIndia has been agreed to be in the form of commodity assistance (providingvaccine only). The cost of AD syringes, Hub cutters and other injection safetyand waste disposal material, and the cost of service delivery of immunizationprogramme is borne by Government of India (GoI). As per the GoI’s discussionwith the Gavi Alliance, this cost is considered the GoI’s contribution for newvaccine introduction. However, the web based APR submission format haspre-designed co-financing calculations , which simultaneously calculate co-financingrequirements. The online tool does not allow country to make any modification;therefore, co-financing component should not be taken into consideration whilereading this document.	

*Note: co-financing is not mandatory for IPV

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

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/programmes_systems/supply_chain/evm/en/index3.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? **February 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? **September 2016**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

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 2015

If 2015 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 2016 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby requests an extension of GAVI support for the years 2015 to 2015 for the following vaccines:

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

At the same time it commits itself to co-finance the procurement of the following vaccines in accordance with the minimum Gavi co-financing levels as summarised in section 7.11 Calculation of requirements.

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

The multi-year support extension is in line with the new cMYP for the years 2015 to 2015, which is attached to

this APR (Document N°**16**). The new costing tool is also attached (Document N°**17**) for the following vaccines:

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

The country ICC has endorsed this request for extended support of the following vaccines at the ICC meeting whose minutes are attached to this APR. (Document N°**18**)

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

7.9. Request for continued support for vaccines for 2016 vaccination programme

In order to request NVS support for 2016 vaccination do the following

Confirm here below that your request for 2016 vaccines support is as per 7.11 Calculation of requirements
Not selected

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 Antigen	Vaccine Type	2010	2011	2012	2013	2014	2015	2016
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID					3.40 %	4.30 %	3.60 %

7.11. Calculation of requirements

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

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	17,531,400	17,531,400	26,571,000	61,633,800
	Number of children to be vaccinated with the first dose	Parameter	#	7,747,748	23,857,281	26,571,000	58,176,029
	Number of children to be vaccinated with the third dose	Parameter	#	7,747,743	22,450,018	26,571,000	56,768,761
	Immunisation coverage with the third dose	Parameter	%	44.19 %	128.06 %	100.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.18	1.18	1.18	
	Stock in Central Store Dec 31, 2014		#	7,038,000			
	Stock across second level Dec 31, 2014 (if available)*		#	0			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#	0			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.00	0.00	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		4.30 %	3.60 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

The closing stock on 31st Dec.2014 is the same as opening stock on 1st. Jan 2015. We do not have second and third level stocks.

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.

Not defined

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

Co-financing group	Intermediate

	2014	2015	2016
Minimum co-financing			
Recommended co-financing as per			
Your co-financing			

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

		2014	2015	2016
Number of vaccine doses	#	31,136,500	95,785,000	112,246,500
Number of AD syringes	#	0	0	107,688,000
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	1,234,725
Total value to be co-financed by GAVI	$	65,541,912	137,106,592	213,800,000

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	2014	2015		
				Total	Government	GAVI
A	Country co-finance	*V*				
B	Number of children to be vaccinated with the first dose	*Table 4*	26,571,000	23,857,281		
B1	Number of children to be vaccinated with the third dose	*Table 4*	7,747,743	23,857,281		
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))*	23,243,237	69,587,603		
E	Estimated vaccine wastage factor	*Table 4*	1.18	1.18		
F	Number of doses needed including wastage	*D x E*		82,113,371		
G	Vaccines buffer stock	***Buffer on doses needed + buffer on doses wasted*** ***Buffer on doses needed** = (D - D of*				

		previous year original approved) x 0.375 **Buffer on doses wasted** = • _if(wastage factor of previous year current estimation < wastage factor of previous year original approved):_ ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375 • _else:_ (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0				
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*				
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0	7,038,000		
H3	**Shipment plan**	*Approved volume*		95,785,000		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		95,785,000		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / T*				

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	**2016**		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	26,571,000	0	26,571,000
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	26,571,000	0	26,571,000
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	79,713,000	0	79,713,000
E	**Estimated vaccine wastage factor**	*Table 4*	1.18		
F	**Number of doses needed including wastage**	*D X E*	94,061,340	0	94,061,340
G	**Vaccines buffer stock**	**Buffer on doses needed + buffer on doses wasted** **Buffer on doses needed** = (D - D of previous year original approved) x 0.375 **Buffer on doses wasted** = • _if(wastage factor of previous year current_	4,480,489	0	4,480,489

		estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375 • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*			
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*	- 13,704,667	0	- 13,704,667
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*	18,075,606	0	18,075,606
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	112,246,500	0	112,246,500
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	107,687,972	0	107,687,972
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	1,234,712	0	1,234,712
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	201,706,961	0	201,706,961
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	4,824,422	0	4,824,422
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)*	6,717	0	6,717
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	7,261,451	0	7,261,451
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)*	213,799,551	0	213,799,551
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.

8. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for <u>and</u> received HSS funds before or during January to December 2014**. All countries are expected to report on:

   a. Progress achieved in 2014

   b. HSS implementation during January – April 2015 (interim reporting)

   c. Plans for 2016

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

For countries that received HSS funds within the last 3 months of 2014, or experienced other delays that limited implementation in 2014, 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 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **15th May 2015**. 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 2015, the HSS reports are expected by GAVI Alliance by September 2015.

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@gavi.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 8.1.2.

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 2014

   b. Minutes of the HSCC meeting in 2015 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2014 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

8. 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.

8.1. Report on the use of HSS funds in 2014 and request of a new tranche

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

8.1.1. Report on the use of HSS funds in **2014**

Please complete Table 8.1.3.a and 8.1.3.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 8.1.3.a and 8.1.3.b.

8.1.2. Please indicate if you are requesting a new tranche of funding **No**

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

These funds should be sufficient to carry out HSS grant implementation through December 2016.

Table 8.1.3a (US)$

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)						27290000
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)						26520000
Remaining funds (carry over) from previous year (*B*)						0
Total Funds available during the calendar year (*C=A+B*)						25620000
Total expenditure during the calendar year (*D*)						17460000
Balance carried forward to next calendar year (*E=C-D*)						6160000
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						81380000

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	41090000	38620000		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the				

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

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)						
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)						
Remaining funds (carry over) from previous year (*B*)						
Total Funds available during the calendar year (*C=A+B*)						
Total expenditure during the calendar year (*D*)						
Balance carried forward to next calendar year (*E=C-D*)						
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Report of Exchange Rate Fluctuation

Please indicate in the table Table 8.3.c below the exchange rate used for each calendar year at opening and closing.

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1 January						
Closing on 31 December						

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2014 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 2015 period are reported in Tables 8.1.3a and 8.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

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)

8.2. Progress on HSS activities in the 2014 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 8.2. 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 8.2: HSS activities in the 2014 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Improve Human Resources to improve cold chain performance	Percentage of staff trained in cold chain, vaccine logistics management, supportive supervision, and MIS and effective vaccine management	50	
Institutional Capacity building to strengthen the cold chain system	Establish the NCCVMRC at NIHFW, Delhi and NCCTC at Pune	100	
Supportive Supervision to ensure quality implementation	Cold chain points receiving supportive supervision on quarterly basis.	100	
Scale up a system for SMS-enabled real time MIS for cold chain and VLM		0	
Implement Multi pronged national BCC strategy development and operational plans	Number of states that have developed their own evidence-based BCC and social mobilization plan for immunization.	33	
Enhance Infrastructure and HR Capacity to develop and implement BCC strategies	Number of key HR trained in BCC strategy development	100	
Develop and Broadcast immunization messages through mass media, mid media and IPC	Number of IPC sessions held using the polio SMNet in underserved areas of UP and Bihar	69	
Monitoring and evaluation for communication through media analysis and other quantitative and qualitative assessment	Number of qualitative and quantitative assessments conducted for ongoing IEC/ BCC interventions	0	
Support Evidence generation to get routine actionable data on system determinants of immunization coverage, avertable burden, programme costs and cost effectiveness of UIP	Establishment of a research network set up for evidence building	50	
Develop and implement the National M&E plan framework	Development and approval of India's National Monitoring & Evaluation Plan on Immunization	100	
GAVI Secretariat to support Ministry	Formed and functional	100	
Build the capacity of existing institutions at the national, state, district and block levels for generating	Number of VPD surveillance workshops conducted at sentinel sites	50	

and interpreting evidence through measles and VPD surveillance for improved policy making			
	Percentage of sentinel sites sending timely and complete VPD surveillance reports	35	
	Number of states where >80% reporting sites send timely and complete measles surveillance reports	100	
Intensified RI monitoring	Percentage of HRAs receiving RI services as per RI microplan	92	
Technical support to the state and district RI task forces in 8 GAVI states	Percentage of districts with district task force on immunization meeting held at least once in a quarter to review RI programme and take appropriate action	100	
Build capacity of frontline workers at state and district levels in 8 GAVI states	(a) 90% of 137000 health workers trained	90	
	(b) 86% of 480, 000 ASHAs trained; and	86	
	(c) 81% of 585, 000 Aanganwadi workers trained as of December 2014.	81	
New vaccine introduction	Facilitated the expansion of pentavalent vaccine roll-out in 12 additional states. Of which 6 states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and West Bengal) are WHO-GAVI supported.		

8.2.1 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**
Objective 1 :- Strengthen vaccine logistics and	1. Draft module for the Effective Cold Chain and Vaccine Management Course has been developed. Phase-II augmentation of NCCMIS has been planned • 2. The modules for ECCVMC have been developed and 1st pilot course to be held from 27th April – 1st May, 2015 • 3. For Supportive supervision State medical Colleges are made Nodal point in 6 states and govt. agencies like SIHFW are nodal in Gujarat & Rajasthan. • 4. Supportive Supervision of cold chain points visits initiated in all 9 states. 2,854 cold chain points visited as of now including District Vaccine Store and PHCs. Supportive supervision visits reports are shared at health facility, district and state level for informing PIP and taking actions for improvement in cold chain management • 5. National EVM improvement plan developed, EVM in Assam, Bihar and Odisha has been completed and Rajasthan is on-going. EVM improvement plans shared by Bihar and Odisha. The states are taking up issues in respective PIPs • 6. National Consultation workshop for development of National Cold Chain and Vaccine Logistics Action Plan (NCCVLAP) held and draft guidelines for further development of NCCVLAP. • 7. Strengthening of NCCTC & NCCVMRC in terms of HR and Cold chain equipments for trainings.
Objective 2 :- Design and implement an electroni	1) 1. RFPs for eVIN software solution, deployment of human resources up to district level and temperature loggers have been launched and are being evaluated

	2) 2. State teams for UNDP are on board, orientated and placed within state/regional DoHFW and are supporting the cold chain & vaccine management in their respective state and division by: i. Providing supportive supervision on the Cold Chain points especially for the implementation of the open vial policy ii. Standardization of the record keeping log books at the district and Cold Chain Points iii. Supporting and standardization of the micro-plans and weekly & monthly reporting formats iv. In the target 10% of the (160 project districts), UNDP state teams have compiled baseline data on cold chain & vaccine management and immunization human resources covering 492 Cold-Chain points in 15 districts (7 Districts of UP, 6 of MP and 2 of Rajasthan. 3) 3. The report of the "rapid assessment of the preparedness of states and districts" for Uttar Pradesh, Madhya Pradesh and Rajasthan is available.
Objective 3 :- Increase in demand for Routine im	1. Each GAVI state is developing state-specific, evidence-based, and integrated communication strategy and operational plans using a consultative process with state and district programme managers, including state specific development partners. 2. 2. As of reporting period, three states (Bihar, MP, and Rajasthan) have submitted RI specific SBCC strategic documents and remaining six states to complete by March 2015. 3. 3. A customized SBCC and IPC Skills Training package (4 modules, Tarang) designed for training of programme managers and to create a cadre of Master Trainers in each state.917 district based trainers trained in IPC skills for immunization and 2,510 staff trained in SBCC strategy development and implementation. In gearing up for the introduction of pentavalent vaccine, new states (e.g., Assam, Jharkhand, Rajasthan) supported with communication planning including state and district level workshops, standardized prototypes of print materials (FAQs, posters, hoardings, press ads) and with implementation guidelines. 4. 4. Mid media campaign on RI launched. (Posters, banners, hoardings etc in all 9 GAVI states). Also 28 states were sent Mission Indradhanush communication guidelines and dissemination plan. 5. 5. Media monitoring and analysis, more than 70% positive & neutral. 6. 6. The report of the "rapid assessment of the preparedness of states and districts" for Uttar Pradesh and Rajasthan is available. 7. For undertaking the preparedness study in Madhya Pradesh, "IMS Health Information and Consulting Services India Pvt. Ltd" has been contracted; data collection will start by end of January, 2015.
Objective 4 :- Monitoring, Evaluation and Research	1. Initial draft of the media analysis report for 2013 and 2014 available for review. Monthly media updates have started since November 2014 2) 2. The terms of reference and potential participants of the research network are being finalized. Concept note on AEFI study has been approved by the Ministry 3) 3. INCHIS has been integrated with "Mission Indradhanush". Baseline survey for Mission Indradhanush completed under INCHIS and for National level sample will be completed soon 4) 4. UNDP contracted PwC (PricewaterhouseCoopers Private Limited) for developing the "National M&E Plan for immunization". Field visits completed in 4 States. Draft M&E plan under review. Final plan will be ready by next quarter 5) 5. A GAVI Secretariat Coordinator and an Assistant have been recruited through UNDP
•Objective 5 :- Leverage the success of the nation	Objective 5: Leveraging the success of the national Polio Surveillance project to strengthen RI service delivery in 8 priority states – WHO 1. All states are now covered under lab based MR surveillance except Andaman & Nicobar Island 2) 2. MNTE completed in all the states 3) 3. VPD surveillance launch workshop held in Haryana in

	December 2014, three laboratories identified for VPD surveillance in Haryana. Identification of laboratories in progress for Uttar Pradesh. 4) 4. 140 district and 7 state workshops conducted for expansion of outbreak based laboratory backed measles surveillance. 5) 5. 92% of the monitored HRAs receiving RI Services. 6) 6. Strengthening RI coverage including pentavalent vaccine introduction in 12 states of which 6 states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and West Bengal) are WHO-GAVI supported. Detailed self assessment of all the key components of RI conducted by all districts and states. The state assessment was evaluated by WHO and key findings shared with GoI. Evaluation of districts is under progress. 7) 7. Total of 38 STF meetings held in 2014. Three states have held at least one STFI in all four quarters of 2014. Bihar, Haryana, MP and WB held more than one STFI meeting during IV quarter. 242 - District Task Force (DTFs) meeting held. 8) 8. 8803 trainers trained through 329 ToT sessions in 287 districts in high priority states.

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

Objective 2: Design and implement an eVIN thatwill enable real time information on cold chain temperatures and vaccine stocksand flows could not be implemented as planned in 2014 because non –availability of required funds with UNDP. The successful award of contract waseither achieved but no procurement could happen. Further, this issue wasdiscussed in many meetings with GAVI officials as well and release of 2ndtranche of HSS support was also requested but it could not happen on time asPFA was not signed and thus resulted in termination of the contract.

8.2.3 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?

No

8.3. General overview of targets achieved

Please complete **Table 8.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2013 from your original HSS proposal.

Table 8.3: 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	2014 Target	Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date				

8.4. Programme implementation in 2014

8.4.1. Please provide a narrative on major accomplishments in 2014, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

HSS support is a catalytic support to Immunization programme in India. The highlights of the immunization programme are:

HIGHLIGHTS<?xml:namespace prefix = "o" />

<!--[if !supportLists]-->• <!--[endif]-->On 27th March 2014, the Regional CertificationCommittee declared South-East Asia Region as polio free.

<!--[if !supportLists]-->• <!--[endif]-->Validation of Maternal and Neonatal TetanusElimination completed in 13 more states and UTs in 2014.

<!--[if !supportLists]-->• <!--[endif]-->In 2014, NTAGI recommended the introduction of threenew vaccines in the UIP: Inactivated polio vaccine (IPV), Measles Rubella (MR)vaccine and Rotavirus vaccine.

<!--[if !supportLists]-->• <!--[endif]-->Pentavalent vaccine scaled up in 12 additional statesin 2014

<!--[if !supportLists]-->• <!--[endif]-->In December 2014, Mission Indradhanush was launched on25th December, 2014 to achieve 90% full immunization coverage of India by year2020.

<!--[if !supportLists]-->**1.** <!--[endif]-->**GLOBAL & NATIONALMILESTONES**

India completes three Polio-free years

<!--[if !supportLists]-->• <!--[endif]-->India reported its last case of polio on 13th January2011. South East Asia Region (SEAR) has been certified Polio free on 27thMarch, 2014, India being a part of this region.

<!--[if !supportLists]-->• <!--[endif]-->As a part of end game strategy, Injectable PolioVaccine (IPV) vaccine is planned to be introduced in the entire country in thelast quarter of 2015 prior to the global switch of t-OPV to b-OPV as a riskmitigation strategy to sustain these efforts.

<!--[if !supportLists]-->**2.** <!--[endif]-->**MNTEValidation**

<!--[if !supportLists]-->• <!--[endif]-->Nineteen of 36 states and union territories had beenvalidated as having achieved MNTE using the WHO recommended methodology by2013.

<!--[if !supportLists]-->• <!--[endif]-->In June, August and December 2014, MNTE validation wasconducted in 13 more states/ UTs. As of December 2014, 32 of the total 36states and union territories have been validated for MNTE.

<!--[if !supportLists]-->• <!--[endif]-->This conclusion is supported by the high percentage ofTT2+ coverage Two NT cases were also verified during the field visit to UP.Also, a high proportion of women in in Uttar Pradesh, Madhya Pradesh, Assam andTripura apply indigenous substances to the umbilical cord that can be harmful.

<!--[if !supportLists]-->**3.** <!--[endif]-->**INTENSIFICATION OF ROUTINEIMMUNIZATION**

<!--[if !supportLists]-->**1.** <!--[endif]-->**Mission Indradhanush:**

<!--[if !supportLists]-->• <!--[endif]-->Launched on 25th December,2014, this seeks to drive toward 90% full immunization coverage of India byyear 2020. The objective of Mission Indradhanush is to ensure high coverage ofchildren with all vaccines in the entire country with a high focus on the 201identified districts.

<!--[if !supportLists]-->**2.** <!--[endif]-->**SpecialImmunization Weeks (SIWs), 2014-15*:* Adrive to reach the unreached**

<!--[if !supportLists]-->• <!--[endif]-->The lessons learnt frompolio programme is being implemented for strengthening of routine immunization by carrying out four SIWs in line with the World ImmunizationWeek in low coverage pockets and in 400,000 high risk areas as identified underpolio programme to target children aged<2 years and pregnant women.

<!--[if !supportLists]-->• <!--[endif]-->More than 8.3 millionchildren aged <2 years and more than 0.93 pregnant women were immunized in the SIWs in 2014-15.

<!--[if !supportLists]-->• <!--[endif]-->Monitoring of the SIWs showed thatmore than 22% of all vaccinated childrenin the high priority states received vaccine for the first time and 42% ofleft-out children in the monitored high risk areas were reached through theSIWs.

<!--[if !supportLists]-->**3.** <!--[endif]-->**SYSTEMSTRENGTHENING**

Training

<!--[if !supportLists]-->• <!--[endif]-->Approximately 1.32 lakhfront line health workers including ANMs, ASHAs and Anganwadi workers have beentrained to improve quality of immunization services in country in calendar year2014.

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

Not applicable

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

Regular review meetings Chaired by the JointSecretary (RCH) , Deputy Commissioner (Immunization) and Deputy Commissioner (UIP) to monitor progresswith implementing partners.

8.4.4. 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.

National Monitoring & Evaluation Plan hasbeen designed by UNDP in consultation with all the development partners.

8.4.5. 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.

The following agencies are involved inimplementing the HSS in addition to Government – UNICEF, UNDP, WHO, ITSU – PHFI.<?xml:namespace prefix = "o" />

Theoverarching goal of GAVI Health system strengthening project is to improveimmunization coverage in India, in alignment with the national targets set bythe Comprehensive Multiyear Plan for immunization (c MYP). The programme isbeing implemented by the Government of India at National level and byrespective State Governments at State level. Areas of support for HSS by otherpartners are:

UNICEF: Strengthen vaccine logistics and cold chain management in poor performingstates through improved human resources capacity, institutional strengtheningand supportive supervision and Increasein demand for Routine immunization through innovations in Behaviour changecommunication (BCC) strategies

UNDP:Design and implement an electronic vaccine intelligence network (eVIN) thatwill enable real time information on cold chain temperatures and vaccine stocksand flows and Monitoring, Evaluation and Research

WHO:Leverage the success of the national Polio Surveillance project to strengthenRI service delivery in 8 priority states

ITSU: ITSU's main objective is to augment technicaland managerial support under UIP for strengthening, revitalization andsuccessful implementation of routine implementation.It hosts the secretariat ofNew Vaccine Introduction Secretariat and the GAVI-Health System strengtheningSecretariat on behalf of Ministry of Health and Family Welfare.

8.4.6. 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.

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 health of citizens. CSOs therefore play a crucial role to advocate for policy changes, generate greater transparency and hold governments and other healthcare stakeholders to account. <?xml:namespace prefix = "o" />

GAVI support to Civil Society Organizations (CSOs) has resulted in launch of Alliance for immunization (Aii) at the national level in Dec.2013 and now has a network of about 180 CSOs. The Catholic Health Association of India (CHAI) facilitates the platform 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 two year old Gavi Approved CSO platform, “Alliance for immunization in India”will continue to partner with the government both at the state and national levels, working towards community ownership of routine immunization.

8.4.7. 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

The management of the funds have been effective

8.5. Planned HSS activities for 2015

Please use **Table 8.5** to provide information on progress on activities in 2015. If you are proposing changes to your activities and budget in 2015 please explain these changes in the table below and provide explanations for these changes.

Table 8.5: Planned 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)	**2015 actual expenditure** (as at April 2015)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Strengthen cold chain management in poor performing states through improved human resources capacity, institutional strengthening and supporting supervision	Improve Human Resources to improve cold chain performance	1630000				
	Supportive Supervision to ensure quality implementation	1410000				
	Implement EVM improvement plans	910000				
	Institutional Capacity building to strengthen the cold chain system	240000				
Design and implement an eVIN that will enable real time information on cold chain temperatures and vaccine stocks and flows		14050000				
Increase demand for RI		7130000				

through a national BCC strategy						
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		4020000				
Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery in 8 priority states		7830000				
		37220000	0			0

8.6. Planned HSS activities for 2016

Please use **Table 8.6** to outline planned activities for 2016. 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 8.6: Planned HSS Activities for 2016

Major Activities (insert as many rows as necessary)	**Planned Activity for 2016**	**Original budget for 2016** (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 2016** (if relevant)
Strengthen cold chain management in poor performing states through improved human resources capacity, institutional strengthening and supporting supervision		3950000			
Design and implement an eVIN that will enable real time information on cold chain temperatures and vaccine stocks and flows		12060000			
Increase demand for		6080000			

RI through a national BCC strategy					
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		3580000			
Leverage the success of the National Polio Surveillance Project to strengthen RI service delivery in 8 priority states		9900000			
		35570000			

8.7. 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@gavi.org

8.8. 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 8.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded

8.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

8.9. Reporting on the HSS grant

8.9.1. 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 8.9.1: Data sources

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

8.9.2. 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.

The Govt. of India sends a quarterly progressreport in the mutually agreed format between government and Gavi Alliance which includes both, Physical andFinancial progress of HSS support. Still, there is too much of repetition herein APR on the same; it would be helpful to avoid duplication.

8.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2014?

Please attach:

1. The minutes from the HSCC meetings in 2015 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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

9.1. 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 2014

9.2. 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 2014

10. 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

The report was endorsed by circulation to implementing partners.

11. Annexes

11.1. 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 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.2. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	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.

11.3. 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 2014 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.4. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	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.

11.5. 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 2014 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.6. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	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. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✔	Doc. 1 Signature JS.pdf **File desc:** **Date/time :** 12/05/2015 07:53:46 **Size:** 2 MB
2	Signature of Minister of Finance (or delegated authority)	2.1	✔	Doc. 1 Signature JS.pdf **File desc:** **Date/time :** 13/05/2015 02:18:46 **Size:** 2 MB
3	Signatures of members of ICC	2.2	✔	Doc. 3 Signature ICC.pdf **File desc:** **Date/time :** 12/05/2015 07:54:22 **Size:** 2 MB
4	Minutes of ICC meeting in 2015 endorsing the APR 2014	5.4	✔	Doc 4. Minutes of ICC meeting 2015.docx **File desc:** **Date/time :** 13/05/2015 02:25:23 **Size:** 12 KB
5	Signatures of members of HSCC	2.3	✔	Doc. 3 Signature ICC.pdf **File desc:** **Date/time :** 13/05/2015 02:26:29 **Size:** 2 MB
6	Minutes of HSCC meeting in 2015 endorsing the APR 2014	8.9.3	✔	Doc 5. Minutes of HSCC meeting 2015.docx **File desc:** **Date/time :** 13/05/2015 08:44:03 **Size:** 14 KB
7	Financial statement for ISS grant (Fiscal year 2014) 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 2014)	6.2.3	✘	No file loaded
9	Post Introduction Evaluation Report	7.2.1	✘	Doc. 9 PIE.pdf **File desc:** **Date/time :** 12/05/2015 07:07:05

				Size: 29 MB
10	Financial statement for NVS introduction grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✔	Doc 10. Financial statement new NVS introduction.docx **File desc:** **Date/time :** 13/05/2015 02:55:13 **Size:** 12 KB
11	External audit report for NVS introduction grant (Fiscal year 2014) if total expenditures in 2014 is greater than US$ 250,000	7.3.1	✔	Doc 11. External audit NVS.docx **File desc:** **Date/time :** 13/05/2015 03:08:53 **Size:** 12 KB
12	Latest EVSM/VMA/EVM report	7.5	✔	Doc.12 EVM final Report.pdf **File desc:** **Date/time :** 12/05/2015 07:11:25 **Size:** 2 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✔	DOC 13- EVM Improvement Master Chart.xls **File desc:** **Date/time :** 12/05/2015 07:13:52 **Size:** 79 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✔	Doc. 14 EVM Improvement Plan and Progress.docx **File desc:** **Date/time :** 12/05/2015 07:14:34 **Size:** 12 KB
16	Valid cMYP if requesting extension of support	7.8	✘	No file loaded
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 2014) signed by the Chief Accountant or Permanent Secretary in	8.1.3	✔	Doc. 19 Copy of HSS Financial Report 2014.xls **File desc:**

	the Ministry of Health			**Date/time :** 13/05/2015 03:40:49 **Size:** 37 KB
20	Financial statement for HSS grant for January-April 2015 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✔	Doc 20..docx **File desc:** **Date/time :** 13/05/2015 03:16:42 **Size:** 12 KB
21	External audit report for HSS grant (Fiscal Year 2014)	8.1.3	✔	Doc 21. External audit report.docx **File desc:** **Date/time :** 13/05/2015 03:23:50 **Size:** 12 KB
22	HSS Health Sector review report	8.9.3	✔	Doc. 22 Annual_Report-Mohfw.pdf **File desc:** **Date/time :** 12/05/2015 07:15:59 **Size:** 3 MB
23	Report for Mapping Exercise CSO Type A	9.1.1	✘	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2014)	9.2.4	✘	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2014)	9.2.4	✘	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 2014 on (i) 1st January 2014 and (ii) 31st December 2014	0	✔	Doc.26.docx **File desc:** **Date/time :** 13/05/2015 03:26:20 **Size:** 12 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✘	No file loaded
28	Justification for changes in target population	5.1	✘	No file loaded

	Other		×	No file loaded