GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

India

Reporting on year: **2012**
Requesting for support year: **2014**
Date of submission: **11/7/2013 10:24:50 AM**

Deadline for submission: 9/24/2013

Please submit the APR 2012 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

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

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

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

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

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

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

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

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

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

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

1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2014
INS			

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

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2012	Request for Approval of	Eligible For 2012 ISS reward
VIG	No	No	N/A
COS	No	No	N/A
ISS	No	next tranche: N/A	N/A
HSS	No	next tranche of HSS Grant N/A	N/A
CSO Type A	No	Not applicable N/A	N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2012: N/A	N/A
HSFP	No	N/A	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 is available here.

2. Signatures

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

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

For the Government of India

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Dr Rakesh Kumar, Joint Secretary (Reproductive and Child Health), MoHFW, Govt. of India	**Name**	Economic Advisor, MoHFW, Govt. of India
Date		**Date**	
Signature		**Signature**	

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

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

2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

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

Name/Title	Agency/Organization	Signature	Date
Dr Vikram Rajan / Public Health Specialist	World Bank		
Mr Billy Stewart/ Senior Health Advisor	DFID		

Dr Genevieve Begkoyian / Chief of Health	UNICEF Country Office		
Dr Nata Menabde/ WHO Representative	World Health Organization Country Office		
Dr Nancy Godfrey/ Director, Office of Population, Health and Nutrition	USAID		
Dr Rajshankar Ghosh /Technical Director	PATH		

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

All comments will be treated confidentially

Comments from Partners:

No additional comments.

Comments from the Regional Working Group:

None.

2.3. HSCC signatures page

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

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

India is not reporting on CSO (Type A & B) fund utilisation in 2013

3. Table of Contents

This APR reports on India's activities between January – December 2012 and specifies the requests for the period of January – December 2014

Sections

4. Baseline & annual targets

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

Number	Achievements as per JRF		Targets (preferred presentation)			
	2012		2013		2014	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation
Total births	2,546,000	2,551,500	5,189,000	5,189,000	5,239,000	18,300,000
Total infants' deaths	78,250	65,832	199,000	199,000	202,000	768,600
Total surviving infants	2467750	2,485,668	4,990,000	4,990,000	5,037,000	17,531,400
Total pregnant women	2,801,250	2,743,500	5,707,000	5,707,000	5,762,000	20,130,000
Number of infants vaccinated (to be vaccinated) with BCG	2,546,000	2,262,905	5,189,000	5,189,000	5,239,000	18,300,000
BCG coverage	100 %	89 %	100 %	100 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with OPV3	2,467,750	2,223,593	4,990,000	4,990,000	5,037,000	17,531,400
OPV3 coverage	100 %	89 %	100 %	100 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with DTP1	2,467,750	1,175,660	4,990,000	4,990,000	5,037,000	17,531,400
Number of infants vaccinated (to be vaccinated) with DTP3	2,467,750	1,196,469	4,990,000	4,990,000	5,037,000	17,531,400
DTP3 coverage	100 %	48 %	100 %	100 %	100 %	100 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	25	15	4,990,000	4,990,000	5,037,000	17,531,400
Wastage[1] factor in base-year and planned thereafter for DTP	1.33	1.18	0.00	0.00	0.00	0.00
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	1,560,000	1,563,441	4,990,000	4,990,000	5,037,000	17,531,400
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	1,560,000	1,207,356	4,990,000	4,990,000	5,037,000	17,531,400
DTP-HepB-Hib coverage	100 %	49 %	100 %	100 %	100 %	100 %
Wastage[1] rate in base-year and planned thereafter (%) [2]	0	15	0	15	25	15
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.18	1.33	1.18	1.33	1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	2,467,750	2,209,905	4,990,000	4,990,000	5,037,000	17,531,400
Measles coverage	100 %	89 %	100 %	100 %	100 %	100 %

Number	Achievements as per JRF		Targets (preferred presentation)			
	2012		2013		2014	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation
Pregnant women vaccinated with TT+	2,801,250	2,258,815	5,707,000	5,707,000	5,762,000	20,130,000
TT+ coverage	100 %	82 %	100 %	100 %	100 %	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 %	-2 %	0 %	0 %	0 %	0 %

** Number of infants vaccinated out of total surviving infants

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

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

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

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 2014 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

Remark: This APR is an update on the original APR 2012 submitted by India through online portal on 14 May 2013. This update has been done to incorporate proposed scale up of Hib as pentavalent (DPT +HepB+Hib) vaccine in additional states of India. the sections related to scale up of pentavalent vaccine only are modified.

As there is already approved GAVI support for pentavalent vaccine introduction in India till December 2015, the Government of India proposes the following scale up plan for vaccine introduction and for continuous support from GAVI Alliance: 8 states which already have pentavalent vaccine in their program, continued GAVI support ; 11 additional states to introduce pentavalent vaccine starting Oct 2014 and remaining 16 states and union territories of India to start pentavalent vaccination in Apr 2015 and Govt. of India request for GAVI support for these states.

The year 2012 estimates, as submitted in APR 2011 were based on the following premises:

- Annual birth cohort for two states (Tamil Nadu and Kerala) as these states had already started pentavalent vaccination in 2011 and<?xml:namespace prefix = o />
- For six states, namely Jammu & Kashmir, Haryana, Goa, Gujarat, Karnataka and Puducherry, which were supposed to start pentavalent vaccination in October 2012, the birth cohort for the period of 3 months was considered.

The reporting in this APR has followed the above premise and done for the entire year for Kerala and Tamil Nadu and the last quarter for rest of the six states. However, as amongst 6 states proposed for the scale up of pentavalent vaccination in 2012, only Haryana started pentavalent vaccination in December 2012. Thus, the reported coverage for pentavalent vaccine till the period of 31st Dec 2012 is lower than originally expected. Moreover, in the early stage of pentavalent vaccine introduction, only new cohort of children received pentavalent vaccine (specially in the first three months of vaccine introduction till March 2012). For the similar reasons, the number of children who had received first dose of pentavalent vaccine during the year is slightly higher than number of children who received third dose of pentavalent vaccine. This does not reflect actual drop out rate.

The number of DPT1 and DPT 3 doses in the table 4 reflects DPT vaccine adminsitered in those states, where pentavalent vaccination could not be started. Though, the coverage with DPT was close to 100% in those areas, the formulaic table use the total surviving infants as denominator. Therefore, proportionate coverage appears to be low. Moreover, even in the Kerala and Tamil Nadu, in the early part of 2012, a few children continued to received DPT (as only new birth cohort offered pentavalent vaccine).

The target beneficiaries for the year 2013 are same as in the original submission on May 2013. These are for 8 states which are currently doing pentavalent vaccination in India

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

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

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

There is no change in the surviving infants for the 8 states already proposed for pentavalent vaccination for the year 2012 and 2013.

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

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

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

The change as reflected above is due to proposed scale up of pentavalent vaccine in additional states of India. It has already been described above.

- 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 upon the stage of pentavalent vaccine introduction. <? xml:namespace prefix = o />

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

Important note: The tables in section 4 and section 7 are formulaic tables, which does not allow any modification. Therefore, these 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 with the assumptions provided as above.

5.2. Immunisation achievements in 2012

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2012 and how these were addressed:

General Remark:<?xml:namespace prefix = o />

The GAVI Alliance new vaccine introduction support to the Govt. of India has been agreed to be in the form of commodity assistance (providing vaccine only). The costs of AD syringes, Hub cutters & other injection safety & waste disposal material, and the cost of service delivery of immunization program in India are borne by the Government of India. As per the GoI discussions with the GAVI Alliance, this cost is considered the GoI's contribution for the new vaccine introduction (equivalent to the co-financing).

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

Major activities conducted and challenges faced in Immunization:

The Government of India has been fully supporting the Universal Immunization Programme (UIP) in the country, with own resources through National Rural Health Mission (NRHM). The NRHM was launched in the year 2005 with a goal to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. The Mission envisages providing effective healthcare to rural population throughout the country by raising the outlays for public funding for health from 0.9% of GDP to 2-3% of GDP. This has already reached to ~1.1% of GDP in the year 2011. One of the main objectives of NRHM is the reduction in child and maternal mortality. The NRHM aims to improve resources, management capacity, accountability and state autonomy through decentralization of funds to the states. States are required to develop project implementation plans (PIPs) and funds are released to the states based on their approved plans. The efforts under the NRHM to date have shown an impact on Health system strengthening and on improving Immunization program service delivery.

The overall health sector planning in India is done under the umbrella of Five Year Plans (FYP). India has finalized 12th FYP for the period of 2012-17 and there is proposed increase of nearly 335% budgetary allocation for health sector in comparison of 11th FYP of India. These initiatives are likely to benefit the health sector. Moreover, there is focus on launch of National Health Mission (NHM), which would be a combined program of existing NRHM and proposed National Urban Health Mission.

Progress in the ongoing activities:

- The year 2012-13 was declared as 'Year of Intensification of Routine Immunization' and a number of activities were done as part of year of IRI. The Government of India, with the support from immunization partners developed National IRI operational guidelines. The Ministry of Health and Family Welfare had communicated IRI plans to all states. The Government had identified 239 priority districts for intensification activities of the total 641 districts. The strategies included in IRI plan for India includes prioritization of the states, districts and blocks for targeted activities to improve RI coverage. These priority districts were those districts with less than 50% fully immunized children as per DLHS 3 conducted in 2007-08. There were a series of planned activities conducted including national and status level advocacy meetings, improved communication and social mobilization plan, regular program review meetings, development of coverage improvement plans by states, institutional capacity building, conducting Immunization weeks, strengthening RI monitoring and supervision, institutionalizing AEFI and VPD surveillance, and strengthening partnership with all stakeholders etc.
- The Govt. of India has been conducting regular review meetings with the states to strengthen RI in the country,
- Immunization weeks were conducted in selected states of India to increase coverage with the antigens.
- National Vaccine Policy of India has been released in 2011 and comprehensive Multi Year Strategic Plan (MYP) for UIP in India (2012-17) is in the final approval stage.
- In recent years, ministry has initiated multiple steps under NRHM to strengthen RI service delivery and quality of immunization:

- Intensified efforts for decentralized planning
- Social mobilization
- Training of all cadre of immunization staff
- Strengthening immunization HMIS, Supportive Supervision and monitoring
- Accelerated disease control
- AEFI & VPD surveillance strengthening
- Strengthening program management capacity
- Introduction & scaling up of under-utilized and new vaccines

- Strengthening Cold Chain system and vaccine logistics management
- Improving injection safety including safe disposal of immunization waste.

  - Immunization Technical Support Unit (ITSU) has been formed in June 2012 by MoHFW in Collaboration with BMGF and Public Health Foundation of India. It is expected that formation of ITSU would help in partially addressing the human resource gap noted at the national level.

Improving Service Delivery

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

Medical officers training in Immunization

- Immunization Handbook for Medical officers, facilitators' guide and training kits were developed for 3 day training in 2008 followed by updating every year.
- The training started in 2009-10 and ~33,000 (53%) of 62,000 MOs are trained till the end of 2012.
- Training progress was slow in majority of the states, mainly due to low priority given to MO training and MOs not relieved for training due to engagement with other programs.
- An evaluation of medical officers training in immunization was conducted jointly by NIHFW, WHO and UNICEF to study the processes and factors affecting the progress, performance and quality of training for medical officers.The study was conducted in 2 phases between Feb to May 2012. A total of 12 states were visited in first phase followed by 6 states for in-depth evaluation in phase II. The findings of this evaluation has been utilised for appropriate modifications and corrective measures.

Health Workers training in immunization

- The health workers are trained on a rolling basis in India with plans for refresher trainings every three year.
- Evaluation of HW training was conducted in 40 districts of 7 states during 2009 when about 50% of HWs were trained for 2 days with Immunization Handbook for HW and Facilitators' guide.
- Based on the results of evaluation, Immunization Handbook for HWs was revised and updated and shared with the states in 2011.
- Around 53,000 (22%) of the 250,000 Health Workers which included ANMs, MPW(M), LHV, HA(M), data handlers and other immunization related field staff were trained by the end of 2012.
- An immunization ready reckoner was developed and printed in 2012 and widely shared with the states for further dissemination.

Intensified Routine Immunization Training of Front-line workers

- During the "Year of Intensification of Routine Immunization" (2012-13), Government of India decided to conduct an intensified and focused training of frontline workers with the objective of enhancing the operational and interpersonal skills of these workers. The goal of this training is to improve the coverage and quality of routine immunization services by reaching the children that have been missed so far.

- There is an initial focus on 9 priority states namely Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Chhattisgarh, Jharkhand, Haryana, Gujarat and West Bengal as these states have a large number of missed children. The training materials have been finalized and the training of trainers and monitoring the training of the frontline workers such as ANMs, LHVs, Anganwadi workers and ASHAs is being done. Nearly 1,250,000 front line workers are to be trained in these states.
- Training materials were developed and printed e.g. Infokits for Health workers and ASHA/AWW; the Facilitators' guide for the trainers; presentations and films on IPC and RI.
- Training modules for Block level program managers supporting immunization were prepared in India and distributed.

Cold Chain handlers training in Immunization

- Vaccine and Cold Chain Handler Handbook was developed, printed and widely disseminated in 2010
- Training started during 2010. Around 24000 (67.5%) of the 35000 cold chain handlers were trained by the end of 2012.An evaluation of Cold chain training was conducted jointly by NIHFW, WHO and UNICEF along with the Medical Officer training evaluation. A total of 12 districts (in 12 states) were covered in this detailed evaluation, which was conducted between February to May 2012.
- National Cold Chain & Vaccine Management Resource Centre (NCCVMRC) is in the final stage of operationalization at NIHFW, <?xml:namespace prefix = st1 />New Delhi, to coordinate & conduct trainings on vaccine logistics and cold chain management, cold chain equipments and monitor National Cold Chain Management Information System (NCCMIS) at website named www.nccvmtc.org
- National Cold Chain Training Centre (NCCTC) at State Health Transport Organization, Pune has been established and is presently functioning as a collaborative centre of NIHFW for cold chain trainings since 2012. This training will restart the trainings for cold chain technicians and officers with financial support of GoI through NIHFW with technical support of UNICEF.
- Since 2007 till end 2012, SHTO with technical support of UNICEF has trained 457 officials on non CFC ILR/DF repair and maintenance and 154 technicians on WIC/WIF repair, maintenance and 98 officials from 16 states on solar cold chain equipment installation, repair and maintenance. The National Cold Chain MIS has been developed by National Cold Chain Training Centre, Pune in 2011.
- EVM Assessments has been conducted in total 10 states of India till 2012. The EVM assessment in 2012 were done Tamil Nadu state.

Monitoring of Routine Immunization Program in India

- The RI monitoring formats have been further revised in 2012 and widely disseminated amongst the states. The intensified monitoring efforts are ongoing in Bihar, Uttar Pradesh, Jharkhand, and a few other states. There has been increased RI monitoring by the government officials and increasingly more number of states have started using the RI monitoring formats.

- A new RI monitoring data tool was prepared by WHO and widely shared with all states to facilitate the data analysis and timely feedback. The discussion on revised monitoring formats and tools were held in all major national and state level UIP review meetings.

- The trainings in RI monitoring have been conducted in a number of states, which plans to roll-out the RI monitoring in India. Punjab, Maharashtra and West Bengal states have also started reporting on the RI monitoring data.

- WHO and other partners are extensively supporting RI monitoring in states such as Bihar and Uttar Pradesh while state governments have taken ownership in additional states such as Karnataka, Maharashtra and Haryana.

Adverse Events Following Immunization Surveillance

There is a thrust on strengthening AEFI surveillance in the country for last few years. This has resulted in the increasing trends in the reporting of serious AEFI cases in India. In the year 2012, a total of 333 serious AEFI cases were reported from 148 districts of 21states of the country.

- National AEFI committee constituted in January 2008. The state AEFI committees have been constituted in all 35 States. Following introduction of new guidelines, regular trainings are conducted at state level (for sensitization of District AEFI committee members and Immunization Program Managers). In 2012;

Maharashtra, Kerala, Chhattisgarh and Haryana conducted state level workshops and nearly 150 officials were trained in these workshops. In 2012, AEFI trainings were conducted for private practitioners also, in the states of Uttar Pradesh and Bihar.

- India joined the WHO Global Network of Post Marketing Surveillance (PMS) with Maharashtra state of India being the participating state. The initial training in the software tool for data entry was conducted in the month of August 2010, followed by another training in Sept 2011. Maharashtra state had started reporting to PMS network in the month of March2012.
- The AEFI surveillance and response operational guidelines were revised in 2010. A total of 25,000 copies of these guidelines have been printed and widely disseminated, to be distributed to all members of State and district AEFI committees and for health facilities up to Primary Health center level in India. In 2011, an abridged version of National AEFI standard operating procedures were prepared and printed. 40,000 copies of these guidelines had been printed and disseminated amongst medical officers across the country.
- To strengthen reporting of AEFI in states introducing LPV, state level AEFI workshops were conducted in Kerala and Haryana in 2012. Similar workshops are planned for 2013 for other states introducing LPV .
- As part of the Measles SIAs preparation, the trainings of district and state level officials have been conducted in AEFI surveillance and reporting on all measles SIA districts in 14 states.
- National AEFI committee met three times in 2012 and reviewed various surveillance aspects. Besides, regular monthly meetings of stakeholders in AEFI and Pharmacovigilance were conducted in 2012 to share updates.
- The National level causality assessment working group conducted the causality assessment of 72 cases available in the national database in 2012. Training of national and state AEFI Committees is scheduled in 2013 to further strengthen the AEFI causality assessment process in India.
- An AEFI Secretariat was established in partnership with PHFI and funding support from WHO. A senior technical position was filled and recruitment of additional staff is under process.
- A National regulatory Authority (NRA) assessment was done in India in 2012, which had emphasis on AEFI surveillance in the country also. The NRA teams visited Haryana and Kerala states of the country. The AEFI surveillance was found satisfactory and India was declared passed in NRA assessment.

Accelerated measles control

India introduced measles second dose (MCV2) for all children in the country starting from November 2010. A total of 21 states which had MCV1 coverage more than 80%, have introduced the measles second dose in UIP at 16 – 24 months of age at the time of 1st DPT booster. 14 states, which had MCV1 coverage of <80% have initiated measles Supplementary Immunization Activities, followed by the introduction of MCV2 in UIP, after 6 months of completion of campaigns in their respective districts . In these campaigns, a total of ~140 million children from 9 months to less than 10 years old in 367 districts were targeted for vaccination in a phased approach. Phase 1 of the campaign was conducted in 45 districts and vaccinated ~12 million children. In phase II, a total of ~36 million children in 153 districts of 14 states were vaccinated. Up till the end of Dec. 2012, while phase III measles catch up campaigns was underway, 94 districts from 5 states had vaccinated around 33 million of the targeted 86 million children in this final phase. Following activities have been done for Measles SIAs in India with partner support:

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

- By the end of Dec. 2012, the ongoing laboratory based measles surveillance system has been operational in 12 states of India (Assam, Andhra Pradesh, Bihar, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Rajasthan, Tamil Nadu and West Bengal).

Introduction of Japanese Encephalitis (JE) vaccination:

- A multi-year (2006-10) plan for implementation of phased JE campaigns in districts is being followed. All 112 endemic districts in 15 states have conducted JE vaccination campaign followed by the introduction of vaccine in RI.
- The repeat campaigns for JE vaccine were conducted in selected districts in 2011 and 2012.
- Based upon the epidemiological profile and NTAGI discussions, the Government of India made a policy decision for the use of 2 dose schedule for JE vaccine in endemic district of India in 2012.

Hepatitis B Vaccine introduction:

- HepB vaccination program in India had started in phased manner, with GAVI support in 2002. It was expanded to 10 states in 2007/08. The GAVI support for Hepatitis B vaccine ended in Dec 2009. Starting since January 2010, The Govt. of India had taken over the procurement of the vaccine from internal funds for all of these 10 states.
- Starting 2011/12, the Hepatitis B vaccination program has been scaled up to the entire country with Government of India's own funds. The vaccine has become the 7th antigen to be part of UIP across the country.
- The hepatitis B vaccination program is successfully running in all states of the country, is continuously reviewed and monitored through various approaches.

Introduction of Hib as Pentavalent vaccine:

- The National Technical Advisory Group on Immunization (NTAGI) recommended the introduction of Hib as Pentavalent vaccine (DPT-HepB-Hib) in the country in 2008.
- The GoI has introduced the HIb as Pentavalent vaccine in 2 states namely Tamil Nadu and Kerala in 2011.
- A Post Introduction Evaluation (PIE) of pentavalent vaccine was conducted by WHO India along with other partner institutions and government organization in July August 2012. The findings of this PIE were widely disseminated and used for corrective measures in these 2 states and also for the scale up of the pentavalent vaccination in additional states of India (Final PIE report is attached as enclosure 9).
- The Govt. of India planned to further scale up of pentavalent vaccine introduction in additional 6 states in 2012. One state Haryana had already started pentavalent vaccination in Dec 2012.

Collaboration with Partner Agencies:

- GoI is working in close collaboration with technical and funding partners in the field of immunization such as WHO, UNICEF, USAID/MCHIP, PATH, UNOPS/NIPI, DFID, World Bank, KfW, BMGF and Immunization Technical Support Unit (ITSU).
- Immunization Partners meetings are held periodically to support GoI in identifying areas for partner support and issues for strengthening the ongoing activities in Routine immunization. A total of 8 major meetings were held in 2012, which were attended and participated by Development Partners. These seven meetings include three national level RI review meetings and meeting each of Immunization Action Group (IAG), India Immunization partners forum, national technical Advisory Group on Immunization (NTAGI), national level cold chain review meetings and meeting on communication for Intensification of RI in India. New vaccine introduction was discussed in all these meetings.
- GoI launched revised RI monitoring strategy in July 2009 by including House to House (H-to-H) component along with modified session monitoring format. The monitoring is being conducted by the state government officials and partners in the states. The data generated is locally analyzed and shared within states/ districts. This concurrent RI monitoring and supportive supervision are ongoing in Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Orissa, Assam, and Jharkhand in collaboration with development partners. These formats were further revised and updated in June 2012.
- Periodic review meetings of Regional/ State level Cold chain officers and for the State EPI Officers were held at regular intervals and supported by development partners.

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

The targets were met in 2 states of India where pentavalent vaccination had started in 2011. However, the targets of pentavalent vaccine could not be reached for other states where vaccination was supposed to be scaled up in 2012. This was attributable to a number of factors including the late supply of the vaccine to the additional states (there was no delay in the supply of the vaccine to Kerala and Tamil Nadu). Once vaccine was supplied to these states, there was a lag time of a few weeks before vaccine could reach to the district and sub-district level facilities, and finally introduced in the immunization program in these 2 states. Therefore, the targets were not met for the pentavalent vaccine.

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

5.3. Monitoring the Implementation of GAVI Gender Policy

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

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

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
Coverage Evaluation Survey 2009	2009	71.5%	71.4%

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

The immunization program in India aims to provide vaccines to all children irespective of gender. The difference in coverage by gender in various antigens is evaluated in the Coverage Evaluation Surveys. The last Coverage Evaluation Survey of 2009 has reported that the differences in the coverage with various antigens was in the range of 1%.

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

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

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

Not Applicable

5.4. Data assessments

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

It is often observed that the reported administrative coverage data of a few states/ districts is higher than the surveyed data and the estimates. The Government of India has started electronic reporting of all immunization coverage data from the block and district level in the country. The immunization coverage data is being reported only through Health Management Information System (HMIS) and the other modes of immunization data reporting have been discontinued. <?xml:namespace prefix = o />

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

As part of streamlining this process, the states are being encouraged to look into the issues and the differences in reported and evaluated coverage during the periodic SEPIO review meetings and also encouraged to verify/validate their reported coverage by comparing with the vaccine consumption in the districts.

The GoI has started an electronic name based Mother and Child Tracking System (MCTS) in the country. The states have started implementing MCTS and it is hoped that with the increased numbers of trainings, this system will also evolve and help in improving data quality reporting in the country.

This is also expected to track and inform beneficiary about the due antigens and help in increasing immunization coverage in India.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **Yes**

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

- The Annual Health Survey (AHS) in India was conducted in selected 9 states of the country in 2010-11.<?xml:namespace prefix = o />
- The District Level Household Survey (DLHS), fourth round was conducted in 2012. The data is being analyzed and the findings from this survey are awaited.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

Health Management Information System (HMIS) was introduced in India in October 2008. It is envisaged that the Health Statistics Information Portal system would facilitate the flow of physical and financial performance from the District level to the State HQ and the Centre using a web based Health Management Information System (HMIS) interface. There has been increased use of the HMIS portal and reporting is improving. However as described in section 5.4.1 above, there are still issues and challenges and continuous efforts are being made to address those issues at various levels by conducting review meetings and imparting trainings to the data entry operators and computer assistants. The training for the use of HMIS system has been completed and currently all the states are sending their reports through HMIS. The system is expected to mature over time.

The initiatives started under NRHM (Alternate Vaccine Delivery system, regular review meetings, trainings of the various levels of functionaries etc.) are being consolidated for the improvement of data quality in India.

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

There has been increasing focus on improving HMIS performance in India. The HMIS data is regularly review from the national level and immediate feedback is provided to the state officials. During the regular review meetings, the feedback is provided to the states and issues are discussed. <?xml:namespace prefix = o />

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

5.5. Overall Expenditures and Financing for Immunisation

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

Exchange rate used	1 US$ = 54	Enter the rate only; Please do not enter local currency name

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

Expenditure by category	Expenditure Year 2012	Source of funding						
		Country	GAVI	UNICEF	WHO	NA	NA	NA
Traditional Vaccines*	51,890,297	51,890,000	0	0	0	99	99	99
New and underused Vaccines**	17,450,396	99	17,450,000	0	0	99	99	99
Injection supplies (both AD syringes and syringes other than ADs)	13,810,297	13,810,000	0	0	0	99	99	99
Cold Chain equipment	3,570,297	3,570,000	0	0	0	99	99	99
Personnel	396	99	0	0	0	99	99	99
Other routine recurrent costs	41,060,297	41,060,000	0	0	0	99	99	99
Other Capital Costs	396	99	0	0	0	99	99	99
Campaigns costs	133,390,297	133,390,000	0	0	0	99	99	99
Grant in aid to the states		570,000	0	0	0	99	99	99
Total Expenditures for Immunisation	261,172,673							
Total Government Health		244,290,297	17,450,000	0	0	891	891	891

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

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

Not applicable.

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

Additional remarks on Table 5.5a:

Table 5.5a is formulaic and doesn't allow any modification. Moreover, the boxes in this table appear to be mandatory in nature and doesn't allow submission of APR unless all the boxes are completed. Therefore, some of the boxes in this table have been entered a numerical value of '99', just to complete the table and to indicate that these boxes are not applicable for India. Similarly, 'NA' has been entered in the last three column names, meant for additional donors. All boxes with either '99' or 'NA' should not be considered while reading this table.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **No, not implemented at all**

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

Action plan from Aide Mémoire	Implemented?
Not Applicable	Not selected

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

Not applicable

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

Not applicable

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **8**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 endorsing this report.

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

India's immunization program is fully internally funded by the national government and therefore, there is no formal Inter-agency Coordination Committee (ICC) in the country. However, the technical assistance and inputs of the Development Partners are taken by 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. A total of 8 major meetings related to routine immunization were held in 2012, which were attended by all Development Partners and GoI.
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- India A meeting of Immunization Action Group (IAG) was held in March 2012. India Immunization Partners meeting was held in August 2012
- A meeting of NTAGI was held in May 2012
- National Immunization Program review meeting: 3 meeting of State EPI Officers were held in 2012. First meeting was held in January 2012 in Guwahati, Assam for North eastern states, second in July 2012 in New Delhi and third in November 2012. Technical and operational issues related to immunization program were discussed in these meetings. Another meeting of State Immunization program Officials and cold chain officers were held in May 2012 in New Delhi. A meeting on Communication for RI was held in September 2012 for 15 states of the country including those states which were scheduled for the scale up of pentavalent vaccine in India.
- A number of Sub National level program review meetings for priority states were held in 2012. These meetings were attended by officials from select priority states and the necessary corrective programmatic suggestions were made in these meetings.
- The technical group of ministry officials and partners met on regular basis for the planning of Hib as pentavalent vaccine introduction in India.

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

- Intensification of Routine Immunization in India
- Strengthening Immunization coverage and reaching the unreached, reducing left-outs and drop-outs
- Recommendation for development of annual plans by GoI and States
- Review of Pentavalent vaccination and future scale up of the vaccination in the country.
- Implementation of MDVP in India
- Development of State PIPs and allocation of NRHM funds for RI
- Status of cold chain equipment, replacement of all CFC equipment

- Revision of micro-plans in UP and Bihar using data available from Polio Immunization Rounds
- Review of progress of HW and MO training in Routine Immunization
- Status of JE vaccine campaigns and issues related to coverage in Routine Immunization
- Discussion on AEFIs in India and those related to Pentavalent vaccine in neighboring countries
- Strengthening Human resources in immunization program in India
- Measles SIAs and their planning in India

Some of the areas noted with concerns were:

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

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

If Yes, which ones?

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

5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

- The Year 2012-13 had been declared as the Year of Intensification of Routine Immunization (IRI) in India and the early part of the 2013 would continue to build and sustain upon the efforts done to strengthen UIP in India in 2012. There is increasing focus on intensified training of front line workers, especially in 9 priority states where maximum numbers of un-immunized children of India are found. It is planned that nearly 1.2 million frontline health workers (ANM, ASHA and AWW) are planned to be trained in intensified training in RI. <?xml:namespace prefix = o />
- The efforts for the capacity building of the medical officers, Supervisors, ANMs and cold chain handlers will be expedited to be completed by 2013.
- 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. These efforts will also be monitored through the existing intensified RI monitoring.
- 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.
- 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.
- 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 introduction and scale up of pentavalent vaccine in the states would be closely monitored and states would be provided regular support and technical assistance for smooth inclusion of vaccine in state programs.
- The Government of India had conducted Immunization Weeks in a number of states of India in 2012. These special immunization weeks would continue in 2013 in low immunization coverage areas.
- The immunization program Performance will be reviewed through regular UIP review meetings held at

various levels, on timely intervals.

- A total of 15 states and UTs in India have already validated for Maternal and neonatal tetanus elimination (MNTE). In 2013, 4 additional states namely (Delhi, Odisha, Mizoram and Uttarakhand) will also be validated for MNTE.
- India would continue to conducted Effective Vaccine Management (EVM) assessment in 2013. There is a plan for EVM assessment in 10 additional states of India in 2013 (In fact, the large scale EVM assessment was completed between Feb to March 2013 and the final data validation and analysis has been done in April 2013). The findings of EVM assessment would be utilized for preparation of detailed cold chain improvement plan and to strengthen cold chain and vaccine management in the country.
- The Post Introduction Evaluation (PIE) has been planned 6 states of India, which have introduced pentavalent vaccine in 2012/2013.
- The implementation of Multi Dose Vial Policy for pentavalent vaccine in Tamil Nadu and Kerala state had been evaluated as part of PIE conducted in 2012. The government of India has already made a policy decision of use of MDVP for all other liquid vaccines for UIP in the country and this policy will be implemented in the country. The successful implementation of this policy is likely to reduce vaccine wastage in the country.

Additional activities scheduled for 2013:

- Measles SIAs will be conducted in additional districts of selected states of the country to complete the campaigns.
- The discussions and deliberation will be held for the further scale up of pentavalent vaccine in additional states of the country.
- Sustaining the Polio free status of India will be ensured through timely and high quality polio SNIDs.
- Rapid Response Teams formed under Emergency Preparedness and Response Plan (EPRP) will be involved to identify low coverage pockets, even in good performing districts.
- The *'Teeka Express'* van will be provided in select districts for vaccine delivery for outreach sessions; for visits to hard to reach areas and to conduct mobile clinics.

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

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

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

Furthermore, India is planning for strengthening of immunization service delivery through Health system strengthening. A separate proposal has been submitted, by the Government of India in Jan 2013, to the GAVI Alliance for funding under HSS support window for the following areas of support:

1. Strengthen vaccine logistics and cold chain management in poor performing states through public-private partnerships and through improved human resources capacity, institutional strengthening and supportive supervision
2. Design and implement an electronic vaccine intelligence network (eVIN) that will enable real-time information on cold chain temperatures and vaccine stocks and flows
3. Increase in demand for routine immunization (RI) through innovations in behaviour change communication (BCC) Strategies
4. Strengthen the evidence base for improved policymaking (at all levels) on programmatic areas like procurement and vaccine delivery and on sequencing and adoption of new antigens
5. Leverage the success of the National Polio Surveillance Project (NPSP) to strengthen RI service delivery in 8 priority states.

It is expected that the support under those activities, in addition to the existing activities would help in strengthening of UIP in India.

5.9. Progress of transition plan for injection safety

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

Please report what types of syringes are used and the funding sources of Injection Safety material in 2012

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
BCG	AD Syringes	Internal funds of Govt. of India
Measles	AD Syringes	Internal funds of Govt. of India
TT	AD Syringes	Internal funds of Govt. of India
DTP-containing vaccine	AD Syringes	Internal funds of Govt. of India

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

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

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

No obstacle encountered.

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

The Hub-cutters are being provided to all vaccinators (ANMs) in UIP in India, which are used for cutting of AD syringes immediately after the use. The Red and Black plastic bags are being provided for each session site for segregation and collection of immunization waste. The safety pits for immunization waste are being constructed under funding provided through NRHM in India. In addition, a number of states in the country have developed public private partnership for immunization and hospital waste disposal mechanism. <? xml:namespace prefix = o />

In general, the immunization waste is transported to the Primary Health Centre, where it is disinfected and disposed off, as per the Central Pollution Control Board (CPCB) guidelines in India.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

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

6.2. Detailed expenditure of ISS funds during the 2012 calendar year

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

6.3. Request for ISS reward

Request for ISS reward achievement in India is not applicable for 2012

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

7.1. Receipt of new & under-used vaccines for 2012 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2012 vaccinations against approvals for 2012

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level in 2012?**
DTP-HepB-Hib	6,234,375	10,505,040	786,080	No

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

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

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)
  - The total doses approved for India for 2012 were initially for 2 states introducing vaccine. However, later on the Government of India communicated the plan for scale up in additional states of India. Thus, total doses received in 2012 are higher than approved in original decision letter. Supply of a portion of vaccine was postponed as states had successfully reduced vaccine wastage and the savings of vaccines for immunizing additional children.
  - There was lower than the expected vaccine utilization in India in 2012. The reason was that as though the pentavalent vaccination in Tamil Nadu and Kerala states, which started vaccination in 2011, continued through the year. However, amongst the additional 6 states, which were supposed to start vaccination in October 2012 only Haryana could start by Dec 2012. It was partially due to the delayed supply of the vaccine. There was no excess stock in 2011.
  - The pentavalent vaccine has replaced one vaccine vial each of DPT and Hepatitis B vaccine in these states, there was no issue of cold chain space in these 2 states. No pentavalent vaccine doses were discarded because of VVM colour change or due to the passing of expiry date.
  - These aspects were also assessed in the Post Introduction Evaluation (PIE) conducted in August 2012. It was noted and there were no stock outs of excess stocks for pentavalent vaccine in India. The pentavalent vaccine introduction did not affect the coverage of the antigens in UIP of these states. The use of MDVP had contributed to the reduction in the vaccine wastage rate in these states
- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

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

- The regular review meetings with the states were held for the proper management of cold chain. It was ensured that states have sufficient numbers of cold chain equipments and the staff is well trained to maintain cold chain properly.
- Prior to the introduction of vaccine in additional 6 states, operational guidelines for pentavalent vaccine introduction were updated, and widely disseminated. These guidelines covered all aspects including cold chain management. All categories of staff in these 2 states were trained, using these guidelines, including in the aspects related to the cold chain management.
- The findings from Post Introduction Evaluation conducted in Tamil Nadu and Kerala states had been used corrective measures and additional planning in states scheduled for scaling up of pentavalent vaccine.
- EVM assessment was done in Tamil Nadu to assess and improve vaccine logisitc management. EVM has been planned in 2013 for other states proposed for the introduction of pentavalent vaccine.
- The vaccine and logistics management practices are being strengthened through various mechanisms. A number of field evaluations including deep dive exercise by ITSU, evaluation of cold chain system in collaboration with INCLEN and vaccine freezing assessment by Indian Council of Medical Research has been carried out in India and these findings are being utilized for further strengthening of vaccine storage practices.

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

Not applicable.

7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	Yes	14/12/2011
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	<span style="FONT-SIZE: 12pt; FONT-FAMILY: 'Times New Roman','serif'; mso-bidi-font-size: 10.0pt; mso-fareast-font-family: Arial; mso-ansi-language: EN-US; mso-fareast-language: EN-US; mso-bidi-language: AR-SA" lang="EN-US">India has planned for the phased introduction of pentavalent vaccine. 2 states have introduced pentavalent vaccine in 2011. A total of 6 additional states of India were scheduled to start pentavalent vaccination by October 2012; however by Dec 2012, only one additional state (Haryana) could start vaccination. <span style="FONT-SIZE: 12pt; FONT-FAMILY: 'Times New Roman','serif'; mso-bidi-font-size: 10.0pt; mso-fareast-font-family: Arial; mso-ansi-language: EN-US; mso-fareast-language: EN-US; mso-bidi-language: AR-SA" lang="EN-US">(Remark: By March 2013 rest of the five states also started vaccination.)

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **August 2013**

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))

The Government of India (GoI) introduced Hib as pentavalent vaccine in Tamil Nadu and Kerala states, starting December 2011. Subsequently, the GoI requested the World Health Organization Country Office for India to conduct a Post-introduction Evaluation (PIE) of in these 2 states.

WHO planned, led, coordinated and conducted a PIE of pentavalent vaccine in July/August 2012. The standard WHO PIE tools were adapted for India specific requirements. A standard protocol was prepared in consultation with experts from Indian Council of Medical Research, National Institute of Health and Family Welfare, National Centre for Disease Control, National institute of Epidemiology, UNICEF, USAID, WHO (Country Office Regional Office for South-East Asia and Headquarters). A desk review was followed by field visits by, 15 national and international experts, a total 7 selected districts in 2 states. The districts visited were Thiruvallur, Erode, Virudhunagar and Trichy in Tamil Nadu and Trivandrum, Ernakulam and Mallapuram in Kerala. The evaluation teams visited and interacted with national, state, district and facility level health staff and documented field observations. Additionally, exit interviews were conducted with the caregivers at the session sites and a few private practitioners providing immunization were also contacted in these evaluation districts. The complete process evaluation of pentavalent vaccine introduction was done and nearly 200 health officials and other staff at various level and around 180 caregivers of beneficiaries were interviewed in this evaluation.

The major recommendations and findings related to program strengthening and pentavalent vaccination strengthening were shared with the State Governments and national immunization program managers. The states had started appropriate corrective measure on the recommendations through review meetings and sharing of the guidelines and training material.

The final report of PIE is enclosed as annexure.

7.2.3. Adverse Event Following Immunization (AEFI)

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

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

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

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

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

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

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **No**

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

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

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

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

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

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

There has been increasing focus in India on improving Vaccine Preventable Diseases (VPD) surveillance. There have been recent efforts to strengthen surveillance for diseases which are prevented by antigens recently becoming avaibale in India. The Indian Council of Medical research (ICMR) and Ministry of health and Family Welfare, Government of India is supporting these efforts. Additionally, a number of similar surveillance studies are being conducted by premeir medical and research institutions in India. These study findings and data are regularly reviewed and discussed at various technical meetings, during conferences and at review meetings. The findings have guided the further sreas for strengthening and decision making in India.

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)	0	0
Remaining funds (carry over) from 2011 (B)	0	0
Total funds available in 2012 (C=A+B)	0	0
Total Expenditures in 2012 (D)	0	0
Balance carried over to 2013 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

Not applicable

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

Not applicable

Please describe the activities that will be undertaken with any remaining balance of funds for 2013 onwards

Not applicable

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ 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 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	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	
	Response to Q.1 to Q5: The GAVI Alliance new vaccine introduction support to the Govt. of India has been agreed to be in the form of commodity assistance (providing vaccine only). The cost of AD syringes, Hub cutters & other injection safety & waste disposal material, and the cost of service delivery of immunization program is borne by the Government of India. As per the GoI discussions with the GAVI Alliance, this cost is considered the GoI's contribution for the new vaccine introduction. However, the web based APR submission format has pre-designed co-financing calculations, which simultaneously calculate co-financing requirements. The online tool does not allow country to make any modification; therefore, the co-financing component should not be taken into the consideration while reading this APR.	

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

Not applicable

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

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **November 2012**

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

Not applicable.

Additional remark on EVM Assessment in India:

Due to large size of Indian states, EVM in India has been conducted state wise however GMSDs are excluded from the assessments which are important supply chain link. To get a national picture and for making national policy on cold chain and vaccine management there is a need to undertake national EVM and necessary planning for national EVM is being done . Between 2010-2012 five states have done EVM assessment ie MP, Gujrat, MH, WB and TN).Each state has prepared improvement plan which are integral part of the state PIPs.

When is the next Effective Vaccine Management (EVM) assessment planned? **February 2013**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

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 2013

Renewal of multi-year vaccines support for India is not available in 2013

7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

Confirm here below that your request for 2014 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

The request for vaccine requirement is confirmed for 2014 as per the REVISED calculations.

In 2014, the pentavalent vaccine will be introduced in 11 additional states of India. This scale up is planned, starting in Oct 2014. However, as table 4 has provision for entry of annual birth cohort. Therefore, for the year 2014, the revised annual birth cohort reflect cohort in 19 states (eight states which are already doing pentavalent vaccination and 11 states which would start in 2014).

Similarly, starting Apr 2015, remaining 16 states and union territories are also planned to start the pentavalent vaccination. Therefore, in 2015, entire birth cohort should be considered as target cohort.

7.11. Calculation of requirements

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

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	2,485,668	4,990,000	17,531,400	25,007,068
	Number of children to be vaccinated with the first dose	Table 4	#	1,563,441	4,990,000	17,531,400	24,084,841
	Number of children to be vaccinated with the third dose	Table 4	#	1,207,356	4,990,000	17,531,400	23,728,756
	Immunisation coverage with the third dose	Table 4	%	48.57 %	100.00 %	100.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.18	1.18	1.18	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	7,321,000			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	7,321,000			
	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	
g	**Vaccine price per dose**	Table 7.10.1	$		2.04	2.04	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

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

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

Not Applicable

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

Co-financing group	Intermediate

	2012	2013	2014

Minimum co-financing			
Recommended co-financing as per APR 2011			
Your co-financing	0.00	0.00	0.00

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

		2013	2014
Number of vaccine doses	#	20,697,700	73,160,800
Number of AD syringes	#	19,982,800	70,699,700
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	221,825	784,775
Total value to be co-financed by GAVI	$	45,895,500	162,231,500

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

		2013	2014
Number of vaccine doses	#	0	0
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country ^[1]	$	0	0

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

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,563,441	4,990,000	0	4,990,000
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	4,690,323	14,970,000	0	14,970,000
E	Estimated vaccine wastage factor	*Table 4*	1.18	1.18		
F	Number of doses needed including wastage	*D X E*	5,534,582	17,664,600	0	17,664,600
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		3,032,505	0	3,032,505
H	Stock on 1 January 2013	*Table 7.11.1*	7,321,000			
I	Total vaccine doses needed	*F + G – H*		20,697,605	0	20,697,605
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		19,982,781	0	19,982,781
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		221,809	0	221,809
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		42,140,324	0	42,140,324
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		929,200	0	929,200
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)*		128,650	0	128,650
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		2,696,981	0	2,696,981
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)*		45,895,155	0	45,895,155
U	Total country co-financing	*I x country co-financing per dose (cc)*		0		
V	Country co-financing % of GAVI supported proportion	*U / T*		0.00 %		

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

		Formula	2014		
			Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	17,531,400	0	17,531,400
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B X C*	52,594,200	0	52,594,200
E	**Estimated vaccine wastage factor**	*Table 4*	1.18		
F	**Number of doses needed including wastage**	*D X E*	62,061,156	0	62,061,156
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*	11,099,139	0	11,099,139
H	**Stock on 1 January 2013**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*F + G – H*	73,160,795	0	73,160,795
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*	70,699,607	0	70,699,607
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*	784,766	0	784,766
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	148,955,379	0	148,955,379
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	148,955,379	0	3,287,532
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)*	455,165	0	455,165
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	9,533,145	0	9,533,145
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)*	162,231,221	0	162,231,221
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	0.00 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / T*

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

India is not reporting on Health Systems Strengthening (HSS) fund utilisation in 2013

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

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

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

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

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

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

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

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

11. Comments from ICC/HSCC Chairs

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

There are no additional comments. All comments have been documented in the minutes enclosed.

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

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

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

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

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

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

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Signature 1.pdf File desc: Date/time: 5/14/2013 7:59:39 AM Size: 1043427
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature 1.pdf File desc: Date/time: 5/14/2013 8:00:46 AM Size: 1043427
3	Signatures of members of ICC	2.2	✓	Signature Page.pdf File desc: Date/time: 5/14/2013 7:40:39 AM Size: 1755350
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✓	Document 4.pdf File desc: Date/time: 5/14/2013 1:11:09 AM Size: 47559
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✓	Document 6.pdf File desc: Date/time: 5/3/2013 6:08:04 AM Size: 7826
9	Post Introduction Evaluation Report	7.2.2	✓	9. India PIE Report 2012.pdf File desc: Date/time: 5/3/2013 6:08:04 AM Size: 3789532
10	Financial statement for NVS introduction grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	Document 10.pdf File desc: Date/time: 5/3/2013 6:08:04 AM Size: 9207
11	External audit report for NVS introduction grant (Fiscal year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.3.1	✓	Document 11.pdf File desc: Date/time: 5/3/2013 6:08:04 AM Size: 9063
12	Latest EVSM/VMA/EVM report	7.5	✓	12 EVM-Report TN India.pdf File desc: Date/time: 5/14/2013 1:11:09 AM Size: 606170

13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	13_14 EVM-Improvement Plan.pdf File desc: Date/time: 5/14/2013 1:11:09 AM Size: 75463
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	13_14 EVM-Improvement Plan.pdf File desc: Date/time: 5/14/2013 1:11:09 AM Size: 75463
15	External audit report for operational costs of preventive campaigns (Fiscal Year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.6.3	✗	Document 15.pdf File desc: Date/time: 5/3/2013 6:08:04 AM Size: 8866
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 2012 on (i) 1st January 2012 and (ii) 31st December 2012	0	✓	Document 26.pdf File desc: Date/time: 5/3/2013 6:08:04 AM Size: 7950