Annual Progress Report 2008

Submitted by

The Government of

India

Reporting on year: 2008

Requesting for support year: 2010/2011

Date of submission: 14 July 2009

Deadline for submission: 15 May 2009

Please send an electronic copy of the Annual Progress Report and attachments to the following e-mail address: **apr@gavialliance.org**

and any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public.

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

Please note that Annual Progress reports will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance or their delegated authority.

By signing this page, the whole report is endorsed, and the Government confirms that funding was used in accordance with the GAVI Alliance Terms and Conditions as stated in Section 9 of the Application Form.

For the Government of [*Name of Country*]...INDIA.....

Secretary (Health & Family Welfare), Ministry of Health & Family Welfare

Title: .....

Signature: .....

Date: 10/2/09 (नरेश दयाल/NARESH DAYAL) .....

सचिव (स्वास्थ्य एवं प.क.क.)
Secretary (Health & F.W.)
स्वास्थ्य एवं परिवार कल्याण मन्त्रालय
MINISTRY OF HEALTH & F.W.
नई दिल्ली/New Delhi

Economic Advisor, Ministry of Health & Family Welfare

Title: .....

Signature: .....

Date: 3/2/09 .....

(श्रीमति गंगा मूर्ति)
(Smt. GANGA MURTY)
आर्थिक सलाहकार/Economic Adviser
स्वास्थ्य एवं परिवार कल्याण मन्त्रालय
Ministry of Health & F.W.
नई दिल्ली/New Delhi

This report has been compiled by:

Full name: Dr. Sunil D Khaparde

Position: Deputy Commissioner (Imm.)

Telephone: +91-11-23061281

E-mail: sunildkhaparde@gmail.com

ICC Signatures Page

If the country is reporting on ISS, INS, NVS support

We, the undersigned members of the Inter-Agency Co-ordinating Committee 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.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The ICC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
Naresh Dayal, Secretary (Health)	Government of India		10/7/09
Mr. Billy Stewart Senior Health Advisor,	DFID		23/6/09
Ms. Anjali Nayar, Country Director	PATH		22/6/09
Dr. Henri van den Hombergh, Chief of Health	Unicef		19/6/09
Ms. Kerry Pelzman, , Director, PHN	USAID		29.6.09
Dr. Salim Habayeb, WHO Representative	WHO		23/6/09
Dr. G.N.V. Ramana, Lead Health Specialist	World Bank		24/6/09
Dr. Srinath Reddy, President	PHFI		19-6-2009

Comments from partners:
You may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

.....

.....

As this report been reviewed by the GAVI core RWG: y/n

.....

.....

.....

Annual Progress Report 2008: Table of Contents

This APR reports on activities between January - December 2008 and specifies requests for the period January - December 2010.

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided

Table A: Latest baseline and annual targets (*From the most recent submissions to GAVI)*

(Figures are in million)

Number			Targets						
		2007-08	2008-09	2009-10	2010-11	2011-12	2013	2014	2015
Births		10.5	10.7	10.9	11.1	11.2			
Infants' deaths		0.4	0.6	0.6	0.6	0.6			
Surviving infants		10.1	10.1	10.3	10.5	10.6			
Pregnant women		12.24	12.33	12.57	12.81	13.06			
Target population vaccinated with BCG		11.81	10.6	10.8	11.0	11.2			
BCG coverage*		105.7%	100%	100%	100%	100%			
Target population vaccinated with OPV3		10.6	10.1	10.3	10.5	10.6			
OPV3 coverage**		106.8%	100%	100%	100%	100%			
Target population vaccinated with DTP (DTP3)***		11.3	10.1	10.3	10.5	10.6			
DTP3 coverage**		107.9%	100%	100%	100%	100%			
Target population vaccinated with DTP (DTP1)***		10.9	10.1	10.3	10.5	10.6			
Wastage[1] rate in base-year and planned thereafter		25%	25%	25%	25%	25%			
Target population vaccinated with **3rd dose** of Hep B		2.67*	10.1	10.3	10.5	10.6			
…….. Coverage**		23%	100%	100%	100%	100%			
Target population vaccinated with **1st dose** of Hep B		3.10	10.1	10.3	10.5	10.6			
Wastage[1] rate in base-year and planned thereafter		25%	25%	25%	25%	25%			
Target population vaccinated with **1st dose** of Measles		10.1	10.1	10.3	10.5	10.6			
Target population vaccinated with **2nd dose** of Measles		NA	NA	NA	NA	NA			
Measles coverage**		103.1%	100%	100%	100%	100%			
Pregnant women vaccinated with TT+ (TT2+)		10.4	10.1	10.3	10.5	10.6			
TT+ coverage****		89.4%	100%	100%	100%	100%			
Vit A supplement	Mothers (< 6 weeks of pregnancy)	NA	NA	NA	NA	NA			
	Infants (>6 months)								
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100									
Annual Measles Drop out rate (for countries applying for YF)									

Data for 10 Hep B States as submitted in the NUVS application Sep, 2008.
* Number of infants vaccinated out of total births
** Number of infants vaccinated out of 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. For new vaccines check table α after Table 7.1.

Table B: Updated baseline and annual targets (*for* 10 States implementing Hepatitis B expansion programme)

(Figures are in million)

Number		Achievements as per JRF	Targets						
		2008#	2009^	2010^	2011^	2012^	2013	2014	2015
Births		10.97	10.62	10.74	10.86	10.98			
Infants' deaths		0.28$	0.49	0.49	0.49	0.5			
Surviving infants		10.69	10.13	10.25	10.37	10.48			
Pregnant women		12.33	12.33	12.57	12.81	13.06			
Target population vaccinated with BCG		11.16	10.6	10.8	11.0	11.2			
BCG coverage*		104.4%	100%	100%	100%	100%			
Target population vaccinated with OPV3		10.26	10.1	10.3	10.5	10.6			
OPV3 coverage**		95.95%	100%	100%	100%	100%			
Target population vaccinated with DTP (DTP3)***		9.96	10.1	10.3	10.5	10.6			
DTP3 coverage**		93.13%	100%	100%	100%	100%			
Target population vaccinated with DTP (DTP1)***		9.95	10.1	10.3	10.5	10.6			
Wastage[2] rate in base-year and planned thereafter		25%	25%	25%	25%	25%			
Target population vaccinated with **3rd dose** of Hep B		5.38*	10.1	10.3	10.5	10.62			
HepB 3 Coverage**		50.28%	100%	100%	100%	100%			
Target population vaccinated with **1st dose** of Hep B		7.05	10.1	10.3	10.5	10.62			
Wastage[1] rate in base-year and planned thereafter		25%	25%	25%	25%	25%			
Target population vaccinated with **1st dose** of Measles		14.4	10.1	10.3					
Target population vaccinated with **2nd dose** of Measles		NA	NA	NA	NA	NA			
Measles coverage**		134.98%	100%	100%	100%	100%			
Pregnant women vaccinated with TT+ ***(TT2+)***		17.6	10.1	10.3	10.5	10.6			
TT+ coverage****		142.74%	100%	100%	100%	100%			
Vit A supplement	Mothers (< 6 weeks of pregnancy)	NA	NA	NA	NA	NA			
	Infants (>6 months)	NA	NA	NA	NA	NA			
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100									
Annual Measles Drop out rate (for countries applying for YF)									

Data of 10 State implementing Hepatitis B vaccines in the UIP as per JRF -2008 (Administrative data reported by States)
^ Projected population and coverage for 10 States implementing HepB vaccine. Based on projections from Census of India 2001 and current SRS data.
$ This figure not reported in JRF 2008 and derived by subtracting Surviving Infants from Birth as reported in JRF 2008.
* Number of infants vaccinated out of total births
** Number of infants vaccinated out of 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

[2] 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. For new vaccines check table α after Table 7.1.

1. Immunization Programme Support (ISS, NVS, INS)

1.1 Immunization Services Support (ISS)

Were the funds received for ISS on-budget in 2008? (reflected in Ministry of Health and/or Ministry of Finance budget): Yes/No
If yes, please explain in detail how the GAVI Alliance ISS funding was reflected in the MoH/MoF budget in the box below.
If not, please explain why the GAVI Alliance ISS funding was not reflected in the MoH/MoF budget and whether there is an intention to get the ISS funding on-budget in the near future?

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

1.1.2 Use of Immunization Services Support

*In 2008, the following major areas of activities have been funded with the GAVI Alliance **Immunization Services Support** contribution.*

Funds received during 2008 _____
Remaining funds (carry over) from 2007 _____
Balance to be carried over to 2009 _____

Table 1.1: Use of funds during 2008*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines					
Injection supplies					
Personnel					
Transportation					
Maintenance and overheads					
Training					
IEC / social mobilization					
Outreach					
Supervision					
Monitoring and evaluation					
Epidemiological surveillance					
Vehicles					
Cold chain equipment					
Other …… *(specify)*					
Total:					
Remaining funds for next year:					

1.1.3 ICC meetings

How many times did the ICC meet in 2008? 4 times
Please attach the minutes (DOCUMENT N°.....) from all the ICC meetings held in 2008 specially the ICC minutes when the allocation and utilization of funds were discussed.

Are any Civil Society Organizations members of the ICC: [Yes/No] ***YES***
if yes, which ones? Indian Academy of Paediatrics **(IAP)** and PATH

Name of the ICC/HSCC: India Inter-Agency Health Sector Coordinating Committee

Date of constitution of the current ICC/HSCC: The ICC in India was formed in 1995. The ICC was renamed the IHSCC and reconstituted in April 2008.

Organisational structure (e.g., sub-committee, stand-alone): Subcommittees are formed as needed.

Frequency of meetings: Three meetings of ICC/IHSCC were held in 2008. However, there are several existing forums of Immunization partner coordination. These include: the National Technical Advisory Group on Immunization (NTAGI) and its subcommittees, the Immunization Partners' Meetings, and the Joint Review Mission (JRM) of RCH & Common Review Mission (CRM) of National Rural Health Mission (NRHM).

Composition: Government of India Ministry of Health and Family Welfare, World Health Organization (WHO), United Nations Children's Fund (Unicef), World Bank, United States Agency for International Development (USAID), , Department For International Development (DFID), Public Health Foundation of India (PHFI), Indian Academy of Paediatrics (IAP) and Programme for Appropriate Technologies in Health (PATH). The last two (IAP and PATH) are Civil Society Organizations.

Please report on major activities conducted to strengthen immunization, as well as problems encountered in relation to implementing your multi-year plan.

The Government of India (GoI) launched the National Rural Health Mission (NRHM) in 2005. NRH To date, it has already shown a significant impact on Health System strengthening including immunization. One of the goals of the NRHM was to strengthen the infrastructure and also increase the spending on health from 0.9% of the GDP in 1999 to 2-3% of the GDP by 2012. The strategy aims to improve resources, management capacity, accountability and state autonomy through decentralization of funds to the states. In India, the state program and operational needs are very diverse. States are required to develop project implementation plans (PIPs) and funds are released to the states based on these plans.

Progress in on-going activities

- In recent years, ministry has initiated multiple steps under NRHM to strengthen RI service delivery and quality of immunization.
- Intensified efforts for
  - –Improving service delivery
  - –Training of all immunization staff
  - –Strengthening Supervision and monitoring
  - –Accelerated disease control
  - –AEFI surveillance
  - –Strengthening program management capacity
  - –Introduction of under utilized and new vaccines.
  - –Strengthening Cold Chain system
  - –Improving injection safety including safe disposal of immunization waste
- To assess the impact of the interventions, District level evaluation (DLHS -3) has been completed in all districts of the country and partial provisional data are available.

Improving Service Delivery

- Decentralized planning and need based funding.
- Cold chain strengthening through expansion and replacement of CFC equipment.
- Provision of alternate vaccine delivery mechanism and provision of alternate vaccinator for underserved urban and rural areas.
- Provision of 2nd ANM at Sub centres
- Improving mobilization and tracking of drop out through Accredited Social Health Activist ASHA (600,000 in place Source: NRHM)

Increasing institutional deliveries through incentive based scheme Janani Suraksha Yojana (JSY)

Training

Health Workers

- Immunization Handbook for Health Workers developed by GOI in 2006.
- Training of Trainers conducted in 2006 and 2007
- Two day training of HWs is continuing at district level since 2007.
- 110,000 out of 200,000 HWs trained by December, 2008.

Medical Officers

- Immunization Handbook for Medical officers training developed in 2008.
- National Workshop for Master Trainers held in September 08
- 2 Additional National ToTs conducted to fast track Training of MOs in 10 Hep B States
- State/ Regional level ToTs are going on.

State EPI Managers training

- State EPI managers were trained in a 6 day training programme conducted by Government of India in collaboration with WHO HQ, CDC, Unicef, USAID and other partners

Cold Chain training

- National cold chain training center established in 2007 at Pune. All refrigerator mechanics (~400) trained by Dec, 2008
- TOTs for repair of voltage stabilizers started
- Training of WIC/WIF mechanics starting from Dec. 08

Vaccine Management training

- Planned for cold chain officer/ vaccine and logistic manager & SEPIO
- Training planned in 2009

Monitoring of Routine Immunization

- GOI conducts Periodic coverage evaluation surveys to monitor trends and progress National Family Health Survey (NFHS), District Level Household Survey(DLHS), Coverage Evaluation Survey (CES)
- Concurrent monitoring and supportive supervision are ongoing in Uttar Pradesh, Bihar, Jharkhand, Rajasthan, MP, Orissa, Assam, Jharkhand and Bihar in collaboration with development partners
- Electronic monitoring tools like HMIS and RIMS, are in place to monitor district & sub district immunization data
- Ongoing Cold Chain Monitoring and assessment through EVSM and VMAT tools.
- National cold chain assessment was conducted and report published.
- Regional/ State level Cold chain & SEPIO review meetings at regular intervals

Maternal and Neonatal Tetanus Elimination

- Upto 2008, a total of 13 states & Union Territories have been validated for elimination.
- 2 more states (HP & Gujarat) were validated in June 08. .
- States likely to be likely to be taken up for validation in the next phase are Jharkhand, Chhattisgarh, Uttaranchal, Orissa and J&K

Adverse Events Following Immunization (AEFI) Surveillance

- Thrust on strengthening AEFI reporting system in the country.
- National AEFI committee constituted in Jan 2008. AEFI committees have been constituted in all 35 States and 475 distrcts out of 618 districts in the country.
- 10 states have conducted State level AEFI workshops for sensitization of District AEFI committee members and Immunization Programme Managers
- AEFI training is part of HW training.

Strengthening program management capacity

- Under NRHM, program management units are established at all levels.
- Setting up of Technical Support Unit at all levels is proposed through GAVI HSS support.

Introduction of Underutilized and New vaccines

Hepatitis – B

- Hepatitis B vaccine was introduced under Phase I GAVI support in 33 districts and 15 cities.
- Under Phase II GAVI Support, 10 states have introduced Hepatitis B in all districts.
- Immunization Schedule modified in August, 2008 to include Birth dose for Institutional deliveries and to provide 3 doses at 6, 10 14 weeks irrespective of the Birth Dose.

JE vaccination

- A multi year (2006-10) plan for implementation of phased JE campaigns in districts is being followed.
- 62 out of 104 targeted Districts in 12 States have completed JE immunization campaigns. Process for integrating JE vaccine in the Routine programme initiated in the districts following campaigns
- SA14-14-2 live vaccine is being used

Collaboration with Partner Agencies:

- GoI is working in close collaboration with Immunization partners such as, WHO, UNICEF, USAID, Immunization Basics, PATH, and NIPI
- Immunization Partners meetings are held periodically to support GoI in identifying areas and issues for strengthening ongoing activities in Routine immunization.
- 3 such meetings were held in 2008

Attachments:

Three (additional) documents are required as a prerequisite for continued GAVI ISS support in 2010:

a) Signed minutes (DOCUMENT N°……) of the ICC meeting that endorse this section of the Annual Progress Report for 2008. This should also include the minutes of the ICC meeting when the financial statement was presented to the ICC.
b) Most recent external audit report (DOCUMENT N°……) (e.g. Auditor General's Report or equivalent) of **account(s)** to which the GAVI ISS funds are transferred.
c) Detailed Financial Statement of funds (DOCUMENT N°……) spent during the reporting year (2008).
d) The detailed Financial Statement must be signed by the Financial Controller in the Ministry of Health and/or Ministry of Finance and the chair of the ICC, as indicated below:

1.1.4 Immunization Data Quality Audit (DQA)

If a DQA was implemented in 2007 or 2008 please list the recommendations below:

Not Applicable List major recommendations

Has a plan of action to improve the reporting system based on the recommendations from the last DQA been prepared?

YES ☐ *NO* ☐

If yes, what is the status of recommendations and the progress of implementation and attach the plan.

***Please highlight in which ICC meeting the plan of action for the last DQA was discussed and endorsed by the ICC**. [mm/yyyy]*

Please report on any studies conducted and challenges encountered regarding EPI issues and administrative data reporting during 2008 (for example, coverage surveys, DHS, house hold surveys, etc).

List studies conducted:

Periodic surveys conducted in India that capture Immunization related data are

1. National Family Health Survey (NFHS – conducted by Government of India)
2. District Level Household survey (DLHS – Conducted by Government of India)
3. Coverage Evaluation Survey (CES – Conducted by Unicef)

The NFHS 3 and CES 2006 results were available in 2007. DLHS 3 survey was completed in 2008 and the complete results are expected by December, 2009. A brief description of latest DLHS survey and the provisional results available are given below:

District Level Household Survey 2007-2008

The District Level Household and Facility Survey (DLHS-3) is one of the largest ever demographic and health surveys carried out in India, with a sample size of about seven lakh households covering all the districts of the country. DLHS were initiated in 1997 with a view to assess the utilization of services provided by government health care facilities and people's perceptions about the quality of services.

The District Level household Survey (DLHS -3) is the third in the series of district surveys, preceded by DLHS-1 in 1998-99 and DLHS-2 in 2002-04. DLHS-3, like other two earlier rounds, is designed to provide estimates on important indicators on maternal and child health, family planning and other reproductive health services. In addition,DLHS-3 provides information on important interventions of National Rural Health Mission (NRHM). The results of DLHS -3 are published for several major States in the country and the comparison with the previous survey outcome are given in the table below:

DLHS-2 & DLHS-3 Comparison for FIC (Fully Immunized Child)

Sl. No.	Name of the State/UTs	DLHS 2 (2002-04)	DLHS3 (2007-08)	Change (%)
1	Andhra Pradesh	62.0	68.5	6.5
2	Assam	16.0	51.0	35.0
3	Bihar	20.7	41.4	20.7
4	Chandigarh	53.5	73.1	19.6
5	Chhattisgarh	56.9	60.8	3.9
6	Dadra Nagar Haveli	84.6	52.3	-32.3
7	Daman & Diu	56.1	83.5	27.4
8	Delhi	59.2	67.7	8.5
9	Goa	76.9	88.6	11.7
10	Gujarat	54.0	55.5	1.5
11	Haryana	59.1	61.8	2.7
12	Himachal Pradesh	79.3	82.6	3.3
13	Jammu & Kashmir	32.0	63.0	31.0
14	Jharkhand	25.7	54.8	29.1
15	Karnataka	71.3	76.8	5.5
16	Kerala	78.5	79.0	0.5
17	Lakshadweep	64.6	86.9	22.3
18	Madhya Pradesh	30.4	38.5	8.1
19	Maharashtra	70.9	69.3	-1.6
20	Meghalaya	13.5	34.3	20.8
21	Mizoram	32.6	55.3	22.7
22	Orissa	53.3	63.1	9.8
23	Puducherry	89.3	80.6	-8.7
24	Punjab	72.9	78.9	6.0
25	Rajasthan	23.9	50.0	26.1
26	Sikkim	52.7	77.9	25.2
27	Tamil Nadu	91.4	81.6	-9.8
28	Tripura	32.6	38.5	5.9
29	Uttar Pradesh	25.8	31.1	5.3
30	Uttarakhand	44.5	63.3	18.8
31	West Bengal	50.3	75.8	25.5

Green Shaded areas represent States where Hepatitis B has been included in Routine Immunization and Puducherry is small State which started Hepatitis B GAVI – Phase I support

List challenges in collecting and reporting administrative data:

- Paper reports are sent by districts to States and from States to Government of India every month. There are often delays in sending the reports. National level consolidation is tedious and at times takes 2 – 3 months.
- Reports sent only on Paper often have discrepancies and errors and this makes the task of consolidation and analysis difficult.
- Since 2006 GOI has made efforts to collect the Monthly Routine Immunization data in an electronic form and provide tools for data analysis at district level through Routine Immunization Monitoring System (RIMS). Under this system data entered by the districts are directly available for monitoring by States and GoI. In 2008, only about 50% of the districts reported immunization data through RIMS.
- Based on the experience of capturing data in an electronic form for various health programmes, in 2008 GoI developed an integrated electronic data reporting system called Health Management Information System (HMIS). The data entry in this system is done at District and State Level. Along with the other Health programmes, it also captures immunization data. Currently Districts are in a transition phase and have started reporting using this tool also.
- Feedback mechanism to states from National level and from states to districts is also lacking

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2008

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB)

[List new and under-used vaccine introduced in 2008]

With the support of GAVI Alliance, the Government of India (GoI) launched a Hepatitis B pilot project in 15 cities and 33 districts in 2003. In 2005, a proposal for Phase II was initiated, to expand the four dose monovalent Hepatitis B program to 11 states with DPT3 coverage of >80% (based on CES 2002 data). The 11 states to be included in phase II were Jammu & Kashmir, Himachal Pradesh, Madhya Pradesh, Chhattisgarh, Punjab, West Bengal, Andhra Pradesh, Karnataka, Tamil Nadu, Kerala and Maharashtra. Following funding support from GAVI for the phase II expansion, the GoI completed the process of administrative approvals for introducing hepatitis B vaccine in 11 States by November 2007. Chhattisgarh State did not start the programme because of cold chain storage problems. The remaining 10 States have introduced Hepatitis B vaccine. The dates of introduction in the 10 States are:

Andhra Pradesh	Nov, 2007
Himachal Pradesh	Feb, 2008
Jammu and Kashmir	Jan, 2008
Karnataka	Jan, 2008
Kerala	Dec, 2007
Madhya Pradesh	Feb, 2008
Maharashtra	Jul, 2008
Punjab	Jan, 2008
Tamil Nadu	Jan, 2008
West Bengal	Apr, 2007

The 10 states to be covered in Phase II, do not cover 11 districts and 6 cities that were included in the pilot project. The GoI has taken the appropriate steps to fully support the Hepatitis B program in these 11 districts and 6 cities with GOI's own funds.
Currently, a policy decision is being sought by the GoI to replace the monovalent Hepatitis B program with a combination vaccine. In April 2008, a subcommittee of the National Technical Advisory Group on Immunization (NTAGI) made a recommendation for the introduction of a DPT +Hepatitis B + Hib pentavalent vaccine. Based on NTAGI recommendation, GoI requested support from GAVI for introduction of liquid pentavalent vaccine in a 10 dose presentation under the New Vaccine Support initiative in September, 2008. GAVI has given conditional approval. GoI has submitted replies to GAVI Conditionalities.

[List any change in doses per vial and change in presentation in 2008]

No Change

Dates shipments were received in 2008.*

Vaccine	Vials size	Total number of Doses	Date of Introduction	Date shipments received (2008)	
Hepatitis B	10 dose	20,507,550	January, 2008 in 10 States	Jul-08	5,000,000
				Aug-08	5,373,900
				Aug-08	2,000,000
				Aug-08	1,111,600
				04-Dec-08	2,633,500
				16-Dec-08	1,000,000
				04-Dec-08	1,830,550
				23-Dec-08	1,000,000
				10-Dec-08	558,000
					20,507,550

**source: Unicef*

Please report on any problems encountered.

[List problems encountered]

- Although the vaccine was received in the 1st quarter of 2007 the introduction of the vaccine was delayed due to delays in administrative processes. This was mostly because of the considerations whether to use a monovalent preparation or to go for Combination vaccine
- Chhattisgarh, one of the 11 States chosen for introduction of Hepatitis B vaccine could not introduce the vaccine due to constraints in cold chain space. Hence, finally Hepatitis B was introduced in 10 States only.
- West Bengal went ahead and introduced the vaccine in April, 2007 as soon as they received the stock and, in the course of the programme the state had apprehensions about accepting further stocks of vaccines in VVM Stage 2 (VVM Usable) thereby leading to prolonged vaccine stock out in the State.
- Maharashtra was the last State to introduce the vaccine in July 2008 due to operational reasons.
- Orientation meetings were conducted by a few States only prior to launch of the programme. No structured trainings on the technical and operational aspects on implementing a new vaccine introduction was carried out prior to launch.

An Operational Guide for Hepatitis B Vaccine in UIP has been published now and the training on hepatitis B vaccine has been integrated into the Routine Immunization training for Medical Officers.

1.2.2. Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

[*List activities*]

Coverage:

Although there was delay in introduction, the coverage has picked up with in few months showing acceptance by community and Health Workers.

Hep B Coverage for 10 States Jan-Dec, 2008								
Sl. No	State	Target Infants 2008	Hep I		Hep II		Hep III	
			Number	%	Number	%	Number	%
1	Jammu & Kashmir*	358,724	213582	60%	159468	44%	127857	36%
2	Punjab	466,843	358889	77%	294949	63%	258801	55%
3	Himachal Pradesh	124,428	78017	63%	67584	54%	19801	16%
4	Madhya Pradesh	1,896,389	1112208	59%	901353	48%	722096	38%
5	Kerala	544,098	368698	68%	332910	61%	323971	60%
6	Tamil Nadu	1,126,663	889775	79%	741779	66%	670841	60%
7	West Bengal	1,752,757	428300	24%	158220	9%	95815	5%
8	Andhra Pradesh	1,523,783	1884552	124 %	1834999	120 %	1931600	127%
9	Maharashtra	1,939,275	1273148	66%	979640	51%	791859	41%
10	Karnataka*	959,335	443603	46%	437199	46%	433522	45%
	Total	10,692,295	7050772	66%	5908101	55%	5376163	50%

Source: JRF – 2008 data (provisional).

*Data from 4 districts in these states not available

Data from Pilot areas which introduced Hepatitis B vaccine under GAVI Phase I support (11 districts and 6 cities outside 10 Hep B States under GAVI Phase II support are fully supported by GoI 2008)

Hep B Coverage for Pilot Areas Jan-Dec, 2008									
Sl. No.	State	District/City	Target Infants 2008	Hep I		Hep II		Hep III	
				Number	%	Number	%	Number	%
1	Haryana	Ambala	26,508	19027	72%	17512	66%	17783	67%
		Panchkula	12,647	3975	31%	3197	25%	2663	21%
2	Assam	Sibsagar	29,283	13421	46%	10681	36%	8932	31%
		Jorhat	24,795	16351	66%	16324	66%	15137	61%
3	Orissa	Sundargarh	40,962	35584	87%	32519	79%	29929	73%
4	Gujarat	Ahmedabad	91720	83496	91%	74740	81%	70514	77%
		Surat	35,948	37523	104%	36886	103%	39980	111%
		Vadodara	32686	28495	87%	26546	81%	26159	80%
5	Goa	Goa	24,174	26662	110%	22462	93%	22716	94%
6	Lakshadweep	Lakshadweep	1,107	873	79%	843	76%	671	61%
7	Pondicherry	Pondicherry	17,824	12400	70%	13539	76%	12024	67%
8	Uttar Pradesh	Kanpur(U)	135,997	35718	26%	30519	22%	27419	20%
		Lucknow	65563	11370	17%	9372	14%	7387	11%
9	A & N Islands	A & N Islands	6,526	5949	91%	6013	92%	5655	87%
10	Rajasthan	Jaipur	178,748	37676	21%	24977	14%	22619	13%
11	Uttaranchal	Nainital	16,299	12791	78%	11375	70%	10206	63%
12	Delhi	Delhi	306,210	179424	59%	137769	45%	127129	42%
Total			1020489	560,735	54%	475,274	45%	446,923	43%

Source : GOI

National Advocacy Meet: A meeting of key Stake holders such as Directors of Health and the State Immunization officers from 10 Hepatitis B vaccine implementing States and 5 small States/ Union Territories implementing Hepatitis B vaccine since GAVI Phase I support, was conducted at Puducherry from 3-5th December, 2008. A comprehensive review of the Universal Immunization Programme was followed by stake holder consultation on draft Operational Guidelines on and discussions on the Hepatitis B introduction activities.

Training: In 2008, Government of India have developed a set of training material for training of Medical Officers consisting of a Handbook on Immunization, Facilitators' Guide and a Training kit (consisting a set of posters, interactive games, Flip chart material etc), with an aim to train all the 60,000 Medical Officers in the country. The training program is of 3 days including half a day of field visit with a batch size of 20-25 participants.

Recently, Government of India has published, "Operational Guidelines for Hepatitis B Vaccine in the Universal Immunization Programme". In the 10 States and 17 pilot areas implementing Hepatitis B vaccine, the training on this vaccine has been integrated into the 3 day training on Routine Immunization for Medical Officers.

The training of trainers has been ongoing in the 10 hep B states with an objective of developing a pool of about 4-8 (average 6) trainers in each district who in turn will conduct the MO training in batches. About 60 such ToT batches are planned.

For Health Worker orientation on Hepatitis B, training material such as a Flip Chart presentation and multi fold information brochure have been developed based on the material available in the Operational Guidelines for Hepatitis B vaccine in the UIP. The trainers in the districts, will conduct orientation of Health workers at block level.

IEC:

A pamphlet for community leaders has been developed for enlisting their support These pamphlets will be used by health workers during Interpersonal communication with local leaders and Village elders to seek their support.

Posters have been developed for display at Hospitals, PHCs and Health Sub-centres.
A mass media campaign. has been planned and will be taken up following the trainings of Health Workers

Periodic Review: States will conduct periodic review meetings to review the progress of routine Immunization including hepatitis B vaccine. Six monthly review of the programme has been planned at the National level

Programme Monitoring:

Monitoring of hepatitis B vaccine in the 10 States has been integrated into the routine immunization monitoring plan at the state, district and PHC/CHC level. At national level, the programme is being monitored by GoI through field visits and analysis of reported administrative data. Hepatitis B has also been included in the Coverage Evaluation Survey (CES) 2009 being conducted by Unicef.

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

These funds were received on: *[01/08/2008]*

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

Year	Amount in US$	Date received	Balance remaining in US$	Activities	List of problems
2008	$1,100,000	6th June, 08	979,428	Advocacy meeting conducted in December, 08.	No problems
2009	979,428		614294#	1. Training 2. Training Material 3. IEC material 4. Mass media Campaign 5. Programme monitoring 6. Periodic Review	

Based on funds obligated/ spent as on 30/04/2009.

1.2.4. **Effective Vaccine Store Management/Vaccine Management Assessment Unicef**

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[mm/yyyy]*

1.2.5. Effective Vaccine Store Management/Vaccine Management Assessment

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[mm/yyyy]*

If conducted in 2007/2008, please summarize the major recommendations from the EVSM/VMA.

Assessment of Govt. Medical Store Depots (GMSD), Karnal was undertaken using the WHO-UNICEF Effective Vaccine Store Management (EVSM) from 8 to 16 October 2007, in order to evaluate the current status and define gaps that need to be addressed. GMSD Karnal is responsible for receiving all routine vaccines required for distribution to 10 states. In addition, it receives and distributes all the JE vaccines required for the whole of India. During the assessment, system and the documentation of the past 12 months was observed closely. The findings based on each criteria of the EVSM are then reported based on strengths and weaknesses of the current practice. Further in July 2008, National Cold Chain Assessment was carried out and suggested actions for strengthening of all GMSDs and state/ district and sub district stores.

VMA was carried out in the state of Orissa (Dec 2007) and Bihar (April 2008). Action points have been identified, and Government has initiated steps to improve cold chain, vaccine and logistics management. Infrastructure renovation has been started for all 7 GMSDs by awarding contract to public sector undertaking. Cold chain equipments have been procured to meet urgent gaps in capacity, however further procurement will be done to replenish and expand cold chain as per assessment report. GoI will be seeking support from Development Partners in addressing gaps.

A separate assessment of all the 7 GMSDs including the 4 GMSDs storing vaccines was carried out in 2008.

Was an action plan prepared following the EVSM/VMA? **Yes**
If yes, please summarize main activities under the EVSM plan and the activities to address the recommendations and their implementation status.

[List main activities]

When will the next EVSM/VMA* be conducted? *[mm/yyyy]*
1st quarter of 2009 – Jharkhand
1st and 2nd quarter of 2010 – States not yet decided
**All countries will need to conduct an EVSM/VMA in the second year of new vaccines supported under GAVI Phase 2.*

Table 1.2

Vaccine 1: .....Hepatitis B.....	
Anticipated stock on 1 January 2010	**9.10 million doses**
Vaccine 2:	
Anticipated stock on 1 January 2010	**.....**
Vaccine 3:	
Anticipated stock on 1 January 2010	**.....**

1.3 Injection Safety

Are you receiving Injection Safety support in cash or supplies? NO.

If yes, please report on receipt of injection safety support provided by the GAVI Alliance during 2008 (add rows as applicable).

1.3.1 Receipt of injection safety support

One of the most effective interventions by the Government of India (GoI) has been the successful scale-up of injection safety supplies. In 2007, the GoI is providing 100% of financial support for the procurement and distribution of injection safety supplies (including AD syringes).

Please report on receipt of injection safety support provided by the GAVI Alliance during 2007 (add rows as applicable).

Table 1.4: Receipt of injection safety support by the GAVI Alliance

Injection Safety Material	Quantity	Date received

Please report on any problems encountered.

[List problems]

1.3.2. Even if you have not received injection safety support in 2008 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded.

List sources of funding for injection safety supplies in 2008]
Government of India is funding 100% of the cost and supplying AD syringes and other injection safety support (Hub cutters, Red , Black bags for collection of waste, twin buckets, hypochlorite solution etc) to all the States for routine immunization. . Monitoring data from Uttar Pradesh and Bihar, two of the states with the lowest coverage rates and highest populations, have shown significant increases in AD syringe use since 2006. In Uttar Pradesh, AD syringe use has increased from 91% in 2006 to 99% in 2008. (Dec, 2008 monitoring data – 6883 sessions monitored) In Bihar, AD syringe use has increased from 88% in 2006 to 95% in 2008 (Dec, 2008 monitoring data – 4422 sessions monitored).

AD syringes were introduced in India in 2005. As of 2007, the Government of India (GOI) has been providing 100% financial support for procurement and distribution of injection safety supplies. The GOI has introduced AD syringes in all existing routine immunization programs and is committed to support AD syringes for all new vaccines that will be introduced into the routine immunization program

Please report how sharps waste is being disposed of.

[Describe how sharps is being disposed of by health facilities]

The Sharps are disposed as per the Central Pollution Control Board (CPCB) Guidelines. A brief description is as below:
Sharps collected in the puncture proof container of the hub cutter, are brought to the nearest Primary Health Centre where the sharps are disinfected by one of the following methods: a) autoclaving, b) contact with 1% Hypochlorite solution for 30 minutes or c) boiling in water for 10 minutes. The disinfected sharps are then permanently buried in concrete pits specially constructed for the purpose at PHCs, CHCs and Hospitals.

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

[List problems]

There have been no problems as far supply use of AD syringes is concerned.

There were few issues in using the hub cutters. There have been reports of hub cutters not functioning properly and health workers facing difficulty in disposing of sharps. This is mostly because some of the hub cutters supplied 2-3 years earlier had run out of their lifespan and at a few places HWs have been found cutting the needle instead of the hub. Poor waste management of sharp objects generated during Immunization sessions are also observed. Health workers training currently in progress in the country are addressing these issues. New hub cutters have been supplied to all states recently.

GOI is also planning a conduct a review of Injection Safety practices.

1.3.3. Statement on use of GAVI Alliance injection safety support in 2008 (if received in the form of a cash contribution)

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

[List items funded by GAVI Alliance cash support and funds remaining by the end of 2008]

Not Applicable to India

2. Vaccine Immunization Financing, Co-financing, and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization GOI
The purpose of Table 2.1 is to guide GAVI understanding of the broad trends in immunization programme expenditures and financial flows.
Please the following table should be filled in using US $.

Cost Category	Estimated cost per annum in $US			
	Baseline (2007-2008)	2009-2010	2010-2011	2011-2012
Traditional vaccines	$ 30,400,000	$ 35,000,000	$ 37,000,000	$ 40,000,000
New vaccines	$ 5,000,000	$ 108,900,000	$ 89,200,000	$ 91,000,000
Injection supplies	$19,000,000	$ 22,000,000	$ 26,000,000	$ 29,000,000
Training	$ 3,000,000	$5,950,000	$ 6,990,000	$ 7,300,000
Social mobilization	$18,000,000	$ 35,700,000	$ 41,940,000	$ 43,800,000
Monitoring	$ 3,000,000	$ 5,950,000	$ 6,990,000	$ 7,300,000
Surveillance	$ 3,000,000	$ 5,950,000	$ 6,990,000	$ 7,300,000
Other (transportation, cold chain maintenance)	$ 3,000,000	$ 5,950,000	$ 6,990,000	$ 7,300,000
Subtotal Recurrent Costs	**$ 84,400,000**	**$ 225,400,000**	**$ 222,100,000**	**$ 233,000,000**
Cold chain	$ 9,300,000	$ 12,500,000	$ 15,500,000	$ 16,000,000
Subtotal Routine Capital Costs	**$ 9,300,000**	**$ 12,500,000**	**$ 15,500,000**	**$ 16,000,000**
Polio Campaigns	$ 252,000,000	$ 233,000,000	$ 116,000,000	$ 116,000,000
Subtotal Campaigns	**$ 252,000,000**	**$ 233,000,000**	**$ 116,000,000**	**$ 116,000,000**
Grand Total EPI	**$ 345,700,000**	**$ 470,900,000**	**$ 353,600,000**	**$ 365,000,000**
Total Government Health				

Source: Addendum to CMYP Sept, 2008.

Exchange rate used	1$ = INR 43

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the next three years; whether the funding gaps are manageable, challenge, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

NOTE: The application to GAVI to which this annual progress report pertains was not made under the co financing mechanism, hence Tables 2.2.1, 2.2.2, 2.2.3 and 2.3 are not applicable.

Future Country Co-Financing (in US$)

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the excel sheet's "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.
- Then please copy the data from Annex 1 (Tab "Support Requested" Table 2) into Tables 2.2.1 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 (one Annex for each vaccine requested) together with the application.

Table 2.2.1 is designed to help understand future country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete as many tables as per each new vaccine being co-financed (Table 2.2.2; Table 2.2.3; ….)

Table 2.2.1: Portion of supply to be co-financed by the country (and cost estimate, US$)

1st vaccine:……..		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

Table 2.2.2: Portion of supply to be co-financed by the country (and cost estimate, US$)

2nd vaccine:……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

Table 2.2.3: Portion of supply to be co-financed by the country (and cost estimate, US$)

3rd vaccine:……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

Table 2.3: Country Co-Financing in the Reporting Year (2008)

Q.1: How have the proposed payment schedules and actual schedules differed in the reporting year?			
Schedule of Co-Financing Payments	Planned Payment Schedule in Reporting Year	Actual Payments Date in Reporting Year	Proposed Payment Date for Next Year
	(month/year)	(day/month)	
1st Awarded Vaccine (specify)			
2nd Awarded Vaccine (specify)			
3rd Awarded Vaccine (specify)			

Q. 2: How Much did you co-finance?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (specify)		
2nd Awarded Vaccine (specify)		
3rd Awarded Vaccine (specify)		

Q. 3: What factors have slowed or hindered or accelerated mobilization of resources for vaccine co-financing?
1.
2.
3.
4.

If the country is in default please describe and explain the steps the country is planning to come out of default.

3. Request for new and under-used vaccines for year 2010

*Section 3 is to the request new and under-used vaccines and related injection safety supplies for **2010**.*

3.1. Up-dated immunization targets

*Please provide justification and reasons for changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the **WHO/UNICEF Joint Reporting Form** in the space provided below.*

*Are there changes between table A and B? Yes/No **YES***

If there are changes, please describe the reasons and justification for those changes below:

Provide justification for any changes ***in births**:*

The births in the previous APR referred to 11 States. Since Chattisgarh has not implemented the Hepatitis B Programme, only births in 10 States as reported in the JRF 2008 and projections on births for future years is being provided

*Provide justification for any changes **in surviving infants**:*

Please see above. The number of surviving infants is calculated again based on data for 10 States

*Provide justification for any changes **in Targets by vaccine**:*

Targets revised as leaving out Chattisgarh state

*Provide justification for any changes **in Wastage by vaccine**:*

Vaccine 1: Monovalent Hepatitis B vaccine (presentation: liquid 10 dose vial)

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.
- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 3.1 below, using the population data (from Table B of this APR) and the price list and co-financing levels (in Tables B, C, and D of Annex 1).
- Then please copy the data from Annex 1 (Tab "Support Requested" Table 1) into Table 3.2 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 together with the application.

(Repeat the same procedure for all other vaccines requested and fill in tables 3.3; 3.4; .....)

Table 3.1: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children(in million) to be vaccinated with the third dose	*Table B*	#	10.25	10.37	10.48			
Target immunization coverage with the third dose	*Table B*	#	100%	100%	100%			
Number of children (in million) to be vaccinated with the first dose	*Table B*	#	10.25	10.37	10.48			
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	25%	25%	25%			
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc
NOTE: The application to GAVI to which this annual progress report pertains was not made under the co financing mechanism, hence Tables 2.2 and 2.3 are not applicable.

Table 3.2: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses(in million)*	#	43.62	44.14	44.6			
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

* 80% of total annual requirement

Vaccine 2: .....NA.....

Same procedure as above (table 3.1 and 3.2)

Table 3.3: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunisation coverage with the third dose	*Table B*	#						
Number of children to be vaccinated with the first dose	*Table B*	#						
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#						
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.4: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

Vaccine 3: .....NA.....

Same procedure as above (table 3.1 and 3.2)

Table 3.5: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunisation coverage with the third dose	*Table B*	#						
Number of children to be vaccinated with the first dose	*Table B*	#						
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#						
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.6: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

4. Health Systems Strengthening (HSS)

This section is not applicable to India

Instructions for reporting on HSS funds received

1. As a Performance-based organisation the GAVI Alliance expects countries to report on their performance – this has been the principle behind the Annual Progress Reporting –APR- process since the launch of the GAVI Alliance. Recognising that reporting on the HSS component can be particularly challenging given the complex nature of some HSS interventions the GAVI Alliance has prepared these notes aimed at helping countries complete the HSS section of the APR report.
2. All countries are expected to report on HSS on the basis of the January to December calendar year. Reports should be received by 15th May of the year after the one being reported.
3. This section **only needs to be completed by those countries that have been approved and received funding for their HSS proposal before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year can use this as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
4. It is very important to fill in this reporting template thoroughly and accurately, and to ensure that **prior to its submission to the GAVI Alliance this report has been verified by the relevant country coordination mechanisms** (ICC, HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead to the report not being accepted by the Independent Review Committee (IRC) that monitors all APR reports, in which case the report might be sent back to the country and this may cause delays in the release of further HSS funds. Incomplete, inaccurate or unsubstantiated reporting may also cause the IRC to recommend against the release of further HSS funds.
5. Please use additional space than that provided in this reporting template, as necessary.

4.1 Information relating to this report:

a) Fiscal year runs from …….(month) to ……..(month).

b) This HSS report covers the period from ……..(month/year) to ……..(month year)

c) Duration of current National Health Plan is from ……..(month/year) to …….(month/year).

d) Duration of the immunisation cMYP:

e) Who was responsible for putting together this HSS report who may be contacted by the GAVI secretariat or by the IRC for any possible clarifications?

It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.'*

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any clarifications			
Other partners and contacts who took part in putting this report together			

f) Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in terms of accuracy or validity of information and, if so, how were these dealt with or resolved?

This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*

g) In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

4.2 Overall support breakdown financially

Period for which support approved and new requests. For this APR, these are measured in calendar years, but in future it is hoped this will be fiscal year reporting:

	Year								
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amount of funds approved									
Date the funds arrived									
Amount spent									
Balance									
Amount requested									

Amount spent in 2008:
Remaining balance from total:

Table 4.3 note: This section should report according to the original activities featuring in the HSS proposal. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from 0% to 100% completion.. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities.

Please do mention whenever relevant the **SOURCES** of information used to report on each activity. The section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?

Table 4.3 HSS Activities in reporting year (ie. 2008)						
Major Activities	**Planned Activity for reporting year**	**Report on progress[3] (% achievement)**	**Available GAVI HSS resources for the reporting year (2008)**	**Expenditure of GAVI HSS in reporting year (2008)**	**Carried forward (balance) into 2009)**	**Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements**
Objective 1:						
Activity 1.1:						
Activity 1.2:						
Objective 2:						
Activity 2.1:						
Activity 2.2:						
Objective 3:						
Activity 3.1:						
Activity 3.2:						
Support Functions						
Management						
M&E						
Technical Support						

[3] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

Table 4.4 note: This table should provide up to date information on work taking place in the first part of the year when this report is being submitted i.e. between January and April 2009 for reports submitted in May 2009.

The column on Planned expenditure in coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS proposal.
Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right.

Table 4.4 Planned HSS Activities for current year (ie. January – December 2009) and emphasise which have been carried out between January and April 2009

Major Activities	Planned Activity for current year (ie.2009)	Planned expenditure in coming year	Balance available (To be automatically filled in from previous table)	Request for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustments**
Objective 1:					
Activity 1.1:					
Activity 1.2:					
Objective 2:					
Activity 2.1:					
Activity 2.2:					
Objective 3:					
Activity 3.1:					
Activity 3.2:					
Support costs					
Management costs					
M&E support costs					
Technical support					
TOTAL COSTS				(This figure should correspond to the figure shown for 2009 in table 4.2)	

Table 4.5 Planned HSS Activities for next year (ie. 2010 FY) This information will help GAVI's financial planning commitments					
Major Activities	**Planned Activity for current year (ie.2009)**	**Planned expenditure in coming year**	**Balance available (To be automatically filled in from previous table)**	**Request for 2010**	**Explanation of differences in activities and expenditures from original application or previously approved adjustments****
Objective 1:					
Activity 1.1:					
Activity 1.2:					
Objective 2:					
Activity 2.1:					
Activity 2.2:					
Objective 3:					
Activity 3.1:					
Activity 3.2:					
Support costs					
Management costs					
M&E support costs					
Technical support					
TOTAL COSTS					

4.6 Programme implementation for reporting year:

a) Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well.

This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.

b) Are any Civil Society Organizations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

4.7 Financial overview during reporting year:

4.7 note: In general, HSS funds are expected to be visible in the MOH budget and add value to it, rather than HSS being seen or shown as separate "project" funds. These are the kind of issues to be discussed in this section

a) Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No If not, why not and how will it be ensured that funds will be on-budget ? Please provide details.

b) Are there any issues relating to financial management and audit of HSS funds or of their linked bank accounts that have been raised by auditors or any other parties? Are there any issues in the audit report (to be attached to this report) that relate to the HSS funds? Please explain.

4.8 General overview of targets achieved

Table 4.8 Progress on Indicators included in application												
Strategy	**Objective**	**Indicator**	**Numerator**	**Denominator**	**Data Source**	**Baseline Value**	**Source**	**Date of Baseline**	**Target**	**Date for Target**	**Current status**	**Explanation of any reasons for non achievement of targets**

4.9 Attachments

Five pieces of further information are required for further disbursement or allocation of future vaccines.

a. Signed minutes of the HSCC meeting endorsing this reporting form
b. Latest Health Sector Review report
c. Audit report of account to which the GAVI HSS funds are transferred to
d. Financial statement of funds spent during the reporting year (2008)
e. This sheet needs to be signed by the government official in charge of the accounts HSS funds have been transferred to, as below.

Financial Comptroller Ministry of Health:

Name:

Title / Post:

Signature:

Date:

5. Strengthened Involvement of Civil Society Organisations (CSOs)

1.1 TYPE A: Support to strengthen coordination and representation of CSOs

This section is to be completed by countries that have received GAVI TYPE A CSO support[4]

Please fill text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

This is section is not applicable to India

5.1.1 Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please identify conducted any mapping exercise, the expected results and the timeline (please indicate if this has changed).

[4] Type A GAVI Alliance CSO support is available to all GAVI eligible countries.

Please describe any hurdles or difficulties encountered with the proposed methodology for identifying the most appropriate in-country CSOs involved or contributing to immunisation, child health and/or health systems strengthening. Please describe how these problems were overcome, and include any other information relating to this exercise that you think it would be useful for the GAVI Alliance secretariat or Independent Review Committee to know about.

5.1.2 Nomination process

Please describe progress with processes for nominating CSO representatives to the HSCC (or equivalent) and ICC, and any selection criteria that have been developed. Please indicate the initial number of CSOs represented in the HSCC (or equivalent) and ICC, the current number and the final target. Please state how often CSO representatives attend meetings (% meetings attended).

Please provide Terms of Reference for the CSOs (if developed), or describe their expected roles below. State if there are guidelines/policies governing this. Outline the election process and how the CSO community will be/have been involved in the process, and any problems that have arisen.

Please state whether participation by CSOs in national level coordination mechanisms (HSCC or equivalent and ICC) has resulted in a change in the way that CSOs interact with the Ministry of Health. Is there now a specific team in the Ministry of Health responsible for linking with CSOs? Please also indicate whether there has been any impact on how CSOs interact with each other.

5.1.3 Receipt of funds

Please indicate in the table below the total funds approved by GAVI (by activity), the amounts received and used in 2008, and the total funds due to be received in 2009 (if any).

ACTIVITIES	Total funds approved	2008 Funds US$			Total funds due in 2009
		Funds received	Funds used	Remaining balance	
Mapping exercise					
Nomination process					
Management costs					
TOTAL COSTS					

5.1.4 Management of funds

Please describe the mechanism for management of GAVI funds to strengthen the involvement and representation of CSOs, and indicate if and where this differs from the proposal. Please identify who has overall management responsibility for use of the funds, and report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

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

This section is to be completed by countries that have received GAVI TYPE B CSO support[5]

Please fill in text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

5.2.1 Programme implementation

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

[5] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

Please outline whether the support has led to a greater involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Name of CSO (and type of organisation)	**Previous involvement in immunisation / HSS**	**GAVI supported activities undertaken in 2008**	**Outcomes achieved**

Please list the CSOs that have not yet been funded, but are due to receive support in 2009/2010, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2009 / 2010	Expected outcomes

5.2.2 Receipt of funds

Please indicate in the table below the total funds approved by GAVI, the amounts received and used in 2008, and the total funds due to be received in 2009 and 2010. Please put every CSO in a different line, and include all CSOs expected to be funded during the period of support. Please include all management costs and financial auditing costs, even if not yet incurred.

NAME OF CSO	Total funds approved	2008 Funds US$ (,000)			Total funds due in 2009	Total funds due in 2010
		Funds received	Funds used	Remaining balance		
Management costs (of all CSOs)						
Management costs (of HSCC / TWG)						
Financial auditing costs (of all CSOs)						
TOTAL COSTS						

5.2.3 Management of funds

Please describe the financial management arrangements for the GAVI Alliance funds, including who has overall management responsibility and indicate where this differs from the proposal. Describe the mechanism for budgeting and approving use of funds and disbursement to CSOs,

Please give details of the management and auditing costs listed above, and report any problems that have been experienced with management of funds, including delay in availability of funds.

5.2.4 Monitoring and Evaluation

Please give details of the indicators that are being used to monitor performance. Outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Activity / outcome	Indicator	Data source	Baseline value	Date of baseline	Current status	Date recorded	Target	Date for target

Finally, please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

6. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission	14 July 2009	
Reporting Period (consistent with previous calendar year)	Jan-Dec 2008	
Government signatures	X	Please see page 2
ICC endorsed	X	Please see page 3
ISS reported on	Not Applicable	
DQA reported on	Not Applicable	
Reported on use of Vaccine introduction grant	X	Please see Section 1.2.3
Injection Safety Reported on	X	Please see Section 1.3.2
Immunisation Financing & Sustainability Reported on (progress against country IF&S indicators)	X	Please see page 23
New Vaccine Request including co-financing completed and Excel sheet attached	X	Please see section 3.1 & 3.2
Revised request for injection safety completed (where applicable)	Not Applicable	
HSS reported on	Not Applicable	
ICC minutes attached to the report	X	Attached at Annexure 1
HSCC minutes, audit report of account for HSS funds and annual health sector review report attached to Annual Progress Report	X	

7. Comments

ICC/HSCC comments:

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.

Annexure 1(a)

ICC/IHSCC Meeting Minutes
Minutes of the GAVI ICC Meeting

The Inter-Agency Coordination Committee meeting, held on 15th May, 2008 at Committee Room, 1st Floor, Ministry of Health & Family Welfare, was chaired by Mr. G.C. Chaturvedi, Additional Secretary and Mission Director NRHM.

Ms Aradhana Johri, Joint Secretary (Immunization) briefed participants on the progress of development of the GAVI HSS proposal so far. The process has included among other meetings, a preparatory meeting held on 24 April 2008 in the chamber of the Secretary of Health and Family Welfare, and attended among others by the Mission Director, NRHM; WHO; UNICEF and USAID. She *outlined the five key areas of health systems strengthening* that have been prioritised for this application: (i) Strengthening of service delivery to address the large dropout; (ii) Improving governance by providing additional management support and training; (iii) Strengthening data collection by addressing the existing gaps in vaccine management and child tracking; (iv) Strengthening training infrastructure; and (v) Innovations to pilot promising initiatives undertaken by various states and agencies.

The Consultant, Dr Suneeta Singh elaborated on the above mentioned areas, following the format of the GAVI HSS application form. The proposal paper extended the evidence base gaps and barriers analysis and donors mapping. The analysis of the various assessments undertaken in India in the past three years revealed gaps and barriers in the health system that limit the achievement under the Immunization programme of India. These are related to both service and demand issues, many of which are being addressed through domestic or external funding, such as from the World Bank and DFID. The activities prioritised under the GAVI proposal are therefore based on the critical needs that are not being addressed under any other source of financing. The implementation plan to be financed by the GAVI proposal is for the two remaining years of the cMYP and in view of the short time period, interventions with short gestation period but high impact are being proposed. It is proposed that UNICEF would carry out procurement under this plan.

The meeting agreed that the thrust of the *proposal is in tune with existing gaps* in the health systems affecting the efficiency of the immunization programme in India. Discussions held regarding the activities proposed under the plan was as follows:

5. Strengthening of the cold chain

- UNICEF was asked to provide the status of cold chain equipment, manpower, training needs and block level *e*-connectivity through information already available with UNICEF by 30 May, 2008 in order for the Consultants to complete their task.
- District wise data, once available, could be used to prioritize the installation of cold chain equipment.
- UNICEF informed the meeting that the solar ILRs installed in Pune will require a further one year process before WHO pre-qualification could take place. The solar freezers provided by KFW in Maharashtra is yet to be installed. The solar convertible freezers installed in Jharkhand have yet to be evaluated.
- There was consensus that UNICEF would undertake procurement of equipment to accelerate the positioning of equipment.

6. **Establish support units of contractual staff to undertake ringfenced tasks in support of routine immunization management function at national, state and district level**

- Several members recommended that support units proposed should have organic linkages with the government system.
- WHO pointed out that existing structures put in place by other donors should be mapped in order to avoid duplication of efforts.
- The Chair pointed out that it needs to be ensured that these units converge with those put in place under NRHM – RCH II financing.

7. **Strengthening of training infrastructure, materials and dissemination of job aids**

- It was suggested that PPP models may need to be explored to enhance the coverage and meet the shortage in terms of training infrastructure.
- Training in effective vaccine management has been scheduled for mid-level management at zonal level by WHO therefore there is need to ensure that there is no duplication under this proposal.

8. **Additional module on vaccine management system and an inventory of cold chain equipment**

- WHO informed the meeting that RIMS is operational in 200 districts and is in the process of being reviewed to address the gaps in data collection and entry. An additional MIS system supported by NIPI is being developed (by year end) in collaboration with UNICEF which would ensure better management of vaccine availability. The quality of data currently being collected is not satisfactory therefore training will be required to strengthen manpower and data entry. Hardware at these places will also be ensured.
- It was pointed out that RIMS is in the process of being integrated with the HMIS to ensure one integrated source of information and therefore all initiatives should be towards an integrated data information collection system.
- It was suggested that whatever system is to be adopted it may be extended to the block level under GAVI. Logistics & vaccine management should be a part of this system.

5. **Challenge fund to explore innovative technologies**

- In response to a suggestion that the supportive supervision module be scaled up, the Consultant clarified that since it is yet to be fully evaluated, it should be piloted in a few states to assess the feasibility of scale up given diverse cultures and varying managerial capacities of the states.

Other issues discussed were:

Some members suggested that this proposal could also have been proposed under the ISS window. Several other members felt that this corresponded to the activities and objectives being proposed would lead to *increased coverage of immunization through strengthening of health systems*. The proposal covers the six core components of HSS. It was suggested that the Consultants review successful HSS proposals from other countries.

Given the large population and the vast geographical area of the country it is *critical to prioritize the states which will be covered by the GAVI proposal.* It was mentioned by the consultant that the final decision would be made by the government but given the time frame it

would be more useful to prioritize few states with poor performance rather than by prioritizing large number of districts in many states. This would be more manageable and the reporting would be easier. Further the decision will also depend on the costing of the interventions. It was suggested that the EAG states be considered, and then based on the availability of finances the North East states and J&K be given priority.

Members recommended that the *sustainability of the projects beyond the proposal period through alternate mechanisms and funding* be outlined in the proposal.

Responding to a comment on the likely impact on HSS within the short time frame being proposed, Ms. Johri clarified that the interventions *being proposed would strengthen and support ongoing programs that are currently being rolled out* to improve the capability of the country to deliver the immunization program.

In response to a query *on the focus on service delivery provisions* rather than demand-side interventions, it was clarified that the interventions would complement work undertaken under the ongoing demand-side programs by government. *It was agreed that the proposal would describe the ongoing interventions on demand in India.*

The first draft of the application will be submitted to the Ministry on 9 June 2008 for review and feedback. The next ICC meeting and the national consultation will be planned once feedback on the draft application was received.

Annual Progress report (APR) of 2007 for GAVI

- The Salient features and contents of the report were highlighted by Dr Naresh Goel, AC(UIP)
- Dr Pem Namgyal, Ag chief IVD, SEARO stated that according to him the APR was not yet ready to go and needed some more finishing, He stated that the may 15 deadline could be extended in case of India, but the report should be of very high quality. He also emphasized that The ICC should meet regularly and a brief generic TOR along with a list of Partners should be defined.
- Mr Robert Clay, Chief PHN, USAID stated that ICC was a felt need and should be established, and the challenges and problems faced by the immunization programme should be stated as such without changes.
- Mr Billy Stewart, of DFID said the components of Major activities and section 1.2.2 needed a review and rewording.
- Mr Balaji from PATH stated that a ICC was created for the GAVI pilot project for Hepatitis B introduction with specific TOR and a defined list of partners. This could be relooked at.

Meeting ended with thanks to Chair.

INTER AGENCY CO-ORDINATION COMMITTEE (ICC) Meeting held on 15th May 2008

List of the Participants

Function	Title / Organization	Name
Chaired by	AS & MD (NRHM)	Mr. G.C. Chaturvedi
Ministry of Health & Family Welfare, Government of India	Joint Secretary, Health & Family Welfare	Ms. Aradhana Johri
	Dy. Commissioner (Immunization)	Dr. Sunil D. Khaparde
	Assistant Commissioner (UIP)	Dr. Naresh Goel
	Assistant Commissioner (I)	Dr. Anil Kumar
	Consultant	Dr. P. Biswal
	Consultant	Dr. Saurabh Sharma
DFID	Senior Health Advisor	Mr. Billy Stewart
	Health Advisor	
PATH	Programe Manager:JE	Dr. Pritu Dhalaria
	Program Officer	Mr. K.A. Balaji
UNICEF	Consultant (RI)	Mr. Dhananjoy Gupta
	Health Specialist	Dr. Satish Kr Gupta
USAID	Director PHN	Mr. Robert Clay
		Mr. Rajiv Tandon
WHO, INDIA	National Professional Officer	Dr. Sunil Nandraj
		Dr. Paul Francis
WORLD BANK	Health Specialist	Vikram Rajan
WHO SEARO	Acting Team Leader - Immunization & Vaccine Development	Dr. Pem Namgyal
WHO, NPSP	Project Manager	Dr. Hamid Jafari
	National Routine Immunization Team Leader	Dr. Rajeev Gera
		Dr. Sunil Bahl
	Consultant	Ms Suchita Jain
Amaltas Consultant	Consultant	Ms. Sunita Singh
	Consultant	Ms. Sweta Das

Annexure 1(b)

Minutes of the India Health Sector Coordination Committee Meeting August 11, 2008

The India Health System Coordination Committee (IHSCC) meeting was held on 11th August, 2008 at Committee Room, 1st Floor, Ministry of Health & Family Welfare under Chairmanship of Mr. *Naresh Dayal*, Secretary, Health and Family Welfare for reviewing progress on the GAVI HSS proposal. The list of participants is attached. Welcoming the participants the Chairman informed that quite progress has been made in framing the application for GAVI support and requested the members to provide their inputs which would be helpful in completion of the proposal.

The members were briefed on the phased introduction plan of pentavalent vaccine in the Universal Immunization Programme. In the first phase 10 states will be covered where Hep-B vaccination is on going The liquid pentavalent vaccine with 5 dose vial will be procured and used. The members were briefed on progress of development of the GAVI HSS proposal so far. The process has included among others, meetings of the IHSCC on 24 April 2008, another on 15 May 2008. These meetings have helped to finalise the conceptual framework and prioritise possible activities that could be considered for inclusion in the GAVI HSS application.

The participants were informed about the overall objective of the GAVI support which is to support critical interventions to boost immunization through strengthened maternal and child health delivery systems by addressing the gaps in the existing system. The implementation plan to be financed by the GAVI proposal is for the two remaining years of the cMYP i.e. up to March 2011.In view of the limited time period, interventions with short gestation period but high impact are being proposed. The options chosen for financing under the GAVI HSS proposal was based on the ceiling of USD 2.5 per child of the birth cohort per year. This ceiling on funding allows for approximately USD 135 million and therefore the activities included in the proposal required judicious choices to be made.

A presentation was made which outlined the five key areas of health systems strengthening that have been prioritised for this application: (i) Strengthening of cold chain systems to improve services delivery including replacing machines, training cold chain mechanics, setting up training centres and strengthening the central vaccine depots across the country. (ii) Improving governance by providing additional techno-managerial support units at national, state and district level for programme coordination, management of logistics, finances and M&E supervision; (iii) Strengthening data collection by addressing the existing gaps in vaccine management and child tracking; (iv) Strengthening training infrastructure, streamlining and systematising training programmes including development and dissemination of job aids; and (v) Piloting of promising innovations and initiatives undertaken by various states and agencies.

There was consensus on the quality of the application and the process undertaken for the application development as well as for the activities that have been prioritised. The members of IHSCC complimented the combined efforts of the Joint Secretary and the other members from the department for providing guidance in framing the application.

Following suggestions were made during the meeting:

- The thrust of the activities should be in the block or sub-district level as there is a need to build capacity at these points which are also the final outreach points.

- Provision of additional vaccinators at the block &outreach area could be strengthened by providing training to Ayurvedic doctors, nursing school students, contractual staff and even qualified NGO representatives.
- WHO would provide technical support to the Government. The mid term appraisal outlined in the proposal is an excellent idea but needs to be done jointly with partners to avoid bias.
- Issue of Injection Safety and strengthening of systems for urban poor be included in the application.
- Kind of techno-managerial support at the state and district level be clearly spelt out.
- Role of the State Health Missions and the articulation in the State Programme Implementation Plans and District work plans in the GAVI HSS be clearly defined

On the above suggestions, it was clarified that:

- All activities included in the application are prioritised on the basis of those that require immediate attention and can be implemented within the tight time frame.
- The application does focus on building capacity at the block level as most of the activities will be implemented at this level.
- The suggestion of training doctors and nursing students as additional vaccinators is important and could be considered.
- The issue of the urban poor is being taken up under the National Urban Health Mission.
- For injection safety a number of initiatives are in place, however there is still a felt need to include training of health workers regarding the waste disposal to ensure injection safety. This would be included in the job aids and training proposed for health workers.
- The application is embedded within the RCH II, NRHM and that the funds would be received in the RCH flexi pool. The reporting would be through the HMIS review reports and therefore would need to be included in the state and district plans.
- The reporting mechanism will be through the government's existing HMIS,
- The funds from GAVI are to be received in two parts. The funds meant for cold chain strengthening would be received directly by UNICEF to accelerate the process and the rest will be received by the government through the 'flexipool' and will flow to the state and district through State/district health society.

Secretary (H&FW) added the immunization programme is embedded within the IPHS standards of NRHM and therefore is a dynamic process. He suggested that the IPHS be reviewed to contextualise the gaps addressed within the GAVI proposal The Chairman added that the activities included in the application are sustainable beyond the period of the GAVI application. He congratulated the consultant and the RCH programme division on developing an appropriate application. He concluded the meeting by requesting the team to revise the application within a week by incorporating the suggestions made at the meeting and be circulated to members of IHSCC for their approval.

Meeting ended with thanks to the Chair.

Meeting of the India health System Coordination Committee (IHSCC)

11 th August 2008

List of Participants

No	Name	Designation	Organization
1	Ms Aradhana Johri	Joint Secretary	MoHFW
2	Ms Sakuntala 0 Gamlin	Joint Secretary	MoHFW
3	Dr Deoki Nandan	Director	NIHFW
4	Dr Ambujam Nair Kapoor	DOG	ICMR
5	Dr S D Khaparde	DC (Immunization)	MoHFW
6	Dr Naresh Goel	AC (VIP)	MoHFW
7	Dr 0 Baswal	AC(Training)	MoHFW
8	Dr Tarun Seem	Director, NRHM	MoHFW
9	Mr N Kal iappan	Under Secretary(DC)	MoHFW
10	Dr P Biswal	Consultant	MoHFW
11	Dr Saurabh Sharma	Consultant	MoHFW /UNICEF
12	Dr M Bhattacharya	Dean	NIHFW
13	Dr Salim Habayeb	WR (India),	WHO
14	Dr Paul Francis	NPO	WHO
15	Dr Sunil Nandraj	NPO	WHO
16	Tim Peterson	DyPM	NPSP/WHO
17	Dr Rajeev Gera	National RI Team Leader	NPSPIWHO
18	Mr Prasanna Hota	Director	NIPI
19	Ms Kendra Philips	Acting Director Health	VSAID
20	Dr Rajiv Tandon	Senior Advisor, Child Survival	USAID
21	Dr Manoj B Paiki	Programme Officer	PATH
22	Dr Dora Waren	Asst. Country Director	CARE
23	Dr Karan S Sagar	for Country Representative	Immunization Basics, USAID
24	Dr Billy Stewart	Health Advisor	DFID
25	Dr Suneeta Singh	Consultant	Amaltas Consulting
26	Ms Sweta Das	Consultant	Amaltas Consulting
27	Mr Ankur Puri	Head Partnerships	PHFI

Annexure 1 (c)

Minutes of the meeting of the IHSCC meeting for New Vaccine introduction

16 September 2008

First Floor Committee room, Nirman Bhawan

Chair: Shri Naresh Dayal, Secretary (Health and Family Welfare)

Agenda:

- Discussion on the draft application circulated
- Inputs and feedback from members of IHSCC

List of participants is attached

Key Decisions: following issues were raised by Ms Lidija Kamara of WHO-Geneva on the application and the decisions taken on them were:

- **Vaccine vial size:**
  - **Issue -** There are no prequalified manufacturers with a 5 dose presentation of liquid pentavalent vaccine and a demand for the same may impact the timeline for vaccine introduction
  - **Decision -** The application is to be modified to include a 10 dose vial as a startup to the implementation and as and when a 5 dose presentation will be available the programme will shift to that. Earlier the decision to use 5 dose vials was taken in consultation with all development partners in previous meetings. However keeping in view the non-availability of 5 dose vial the application is to be modified to include 10 dose vial.
- **Funding:**
  - **Issue –** The vaccine cost calculations in the application are based on USD 3.6 per dose which is for the 2 dose vial, whereas the cost/dose for a 10 dose vial is USD 2. (The information was provided by Ms Lidija Kamara of WHO in the meeting. This statement was also supported by UNICEF India country office)
  - **Decision –** EFC proposal will be modified to incorporate introduction in 10 states for 3 years from 2009-10 to 2011-12, with a 10 dose vial @ USD 2 per dose.
  - **Issue –** The application should only show the period of GAVI funding and accompanied with a joint letter from Ministry of Health and Finance regarding the allocation of national budgetary resources.
  - **Decision –** As the Ministry of health has its own budgetary provisions, there is no need for a letter from Ministry of Finance. The application will be supported by a commitment from Ministry of Health regarding availability of funding. The same was endorsed by the Economic Advisor, Bureau of Planning.
  - **Issue –** To start the program in April 2009 vaccine procurement orders need to be placed 6 months in advance.
  - **Decision -**
    - The EFC and cabinet approvals will be taken as soon as possible and the process of vaccine procurement started as soon as cabinet approval is obtained.
    - Procurement will be done through UNICEF
    - In case of GAVI support, UNICEF will start processing the tenders after the approval of IRC as agreed by the UNICEF representatives present in the meeting
    - In case of delays in GAVI approvals, the first year procurement to be supported through domestic budget.
- **Surveillance:**
  - **Issue -** Surveillance of Hib disease needs to be instituted to understand the baseline in these 10 states and also study impact
  - **Decision -** ICMR will submit detailed proposal for setting up surveillance sites in 10 states after a facility review in November. All sites which are selected will be made operational by ICMR before vaccine introduction in April. Funding for setting up these sites will be provided by the MOHFW.

- **Other Additions to application on suggestions of members:**
  - Addendum to cMYP to be mentioned in Executive summary
  - AEFI reporting strengthening plan
  - Safe injection practices plan
  - NTAGI recommendations on introduction of Pneumococcal, Measles Rubella, Rubella and Measles SIAs
  - Support from GAVI to be specified as commodity assistance

Meeting of ICC / IHSCC
Date - 16th September 2008
Venue: 1st Floor Committee Room

In Chair: Mr. Naresh Dayal, Secretary, Health & Family Welfare, MoHFW, Govt. of India

S.No	Name	Designation	Organization
1	Mr Naved Masood	AS & FA	MoHFW
2	Mr G C Chaturvedi	AS & MD (NRHM)	MoHFW
3	Ms Aradhana Johri	Joint Secretary (AJ)	MoHFW
4	Ms Sakuntala D Gamlin	JS (SG)	MoHFW
5	Dr S K Bhattacharya	Additional Director General	ICMR
6	Dr Deoki Nandan	Director	NIHFW
7	Dr N Namshum	DC (MCH)	MoHFW
8	Dr S D Khaparde	DC (Immunization)	MoHFW
9	Dr Naresh Goel	AC (UIP)	MoHFW
10	Dr D Baswal	AC(Training)	MoHFW
11	Ms Ganga Murthy	Economic Advisor	MoHFW
12	Dr Tarun Seem	Director, NRHM	MoHFW
13	Mr Avinash Mishra	Director (UIP)	MoHFW
14	Mr Sanjay Prasad	Director Donor Coordination,	MoHFW
15	Mr Rajesh Kumar	Consultant (Finance)	MoHFW
16	Dr Srinath Reddy	Director	PHFI
17	Dr. R K Agrawal	President	IAP
18	Dr S N Mishra	Hony. Gen Secretary	IMA
19	Dr Marzio Babille	Chief Health Section	UNICEF
20	Dr Satish Gupta	Health Specialist	UNICEF
21	Dr Salim Habayeb	WR (India),	WHO
22	Dr Paul Francis	NPO	WHO
23	Dr Sunil Nandraj	NPO	WHO
24	Dr. Hamid Jafari	Project Manager,	NPSP/WHO
25	Mr Prasanna Hota	Director	NIPI
26	Dr Billy Stewart	Health Advisor	DFID
27	Ms Elizabeth Sime	Country Director	CARE
28	Dr Rajiv Tandon	Division Chief, MCHN/UH	USAID
29	Ms Anjali Nayyar	Country Programme Leader	PATH
30	Dr G N V Ramana	Lead Health Spl	World Bank
31	Dr Karan S Sagar	for Country Representative	Immunization Basics. USAID