# Joint Appraisal report 2019

| | |
|---|---|
| **Country** | India |
| **Full JA or JA update**[1] | ☑ **full JA** ☐ JA update |
| **Date and location of Joint Appraisal meeting** | |
| **Participants / affiliation**[2] | |
| **Reporting period** | Q4 2018 – Q3 2019 |
| **Fiscal period**[3] | April - March |
| **Comprehensive Multi Year Plan (cMYP) duration** | 2018 -22 |
| **Gavi transition / co-financing group** | Accelerated transition (2017-2021) |

## 1. RENEWAL AND EXTENSION REQUESTS

**Renewal requests were submitted on the country portal**

| | | | |
|---|---|---|---|
| **Vaccine (NVS) renewal request** (by 15 May)* | Yes x | No ☐ | N/A ☐ |
| **Does the vaccine renewal request include a switch request?** | Yes ☐ | No ☐ | N/A × |
| **HSS renewal request*** | Yes x | No ☐ | N/A ☐ |
| **CCEOP renewal request** | Yes ☐ | No ☐ | N/A × |

** Renewal request for rotavirus vaccine for 2020 (final year of support) was submitted by 15 May 2019. HSS had been approved for 2019 and 2020. Renewal request for 2021 is sought.*

## 2. GAVI GRANT PORTFOLIO

**Existing vaccine support** *(to be pre-filled by Gavi Secretariat)*

| Introduced / Campaign | Date intro | 2018 Coverage (WUENIC) by dose | 2019 Target | | Commitment $ | Comment |
|---|---|---|---|---|---|---|
| | | | % | Children | | |
| **PCV** | 2017 | PCV3: 6% | N/A | 1,404,569 | 180M | WUENIC data reflect status of phased rollout. Gavi support is for 2017-19. |
| **Rota** | 2016 | RV3: 35% | N/A | 8,193,318 | 58.5M | WUENIC data reflect status of phased rollout. Gavi support is for 2018-20. |
| **IPV (fIPV)** | 2015 | IPV1: 75% | N/A | 17,557,111 | 40M | Newly approved IPV support for 50/50 Gavi/GoI cost sharing from 2019-21. |

**Existing financial support** *(to be pre-filled by Gavi Secretariat)*

| Grant | Channel | Period | First disburse-ment | Cumulative financing status (at 30 September 2019) | | | | Compliance | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Comm. | Appr. | Disb. | Util. | Fin. | Audit |
| **HSS2** | WHO/ UNICEF / UNDP/ JSI | 2017-21 | Sep/Oct 2017 | 102.2M | 90.8M | 70.0M | 45.38 M | compliant | N/A |
| **MR Ops Cost** | WHO/ UNICEF | 2018-19 | Jan/Feb 2018 | 8.5M | 8.5M | 8.5M | 7.6M | compliant | N/A |
| **Comments** | | | | | | | | | |
| The $8.5M "MR operational cost" is technical assistance from WHO and UNICEF, re-allocated from the Rota vaccine envelope within Gavi's $500M commitment to India. | | | | | | | | | |

[1] Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, https://www.gavi.org/support/process/apply/report-renew/

[2] If taking too much space, the list of participants may also be provided as an annex.

[3] If the country reporting period deviates from the fiscal period, please provide a short explanation.

**Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future**[4]

| Indicative interest to introduce new vaccines or request HSS support from Gavi | Programme | Expected application year | Expected introduction year |
|---|---|---|---|
| | HPV* | to be determined | |
| | | | |

* Introduction subject to the outcome of a case in the Supreme Court

**Grant Performance Framework – latest reporting, for period 2019** *(to be pre-filled by Gavi Secretariat)*

| Objective | Activity | Activity / Indicator description | Annual Target 2018 | Cumulative Achievements 2018 | Annual Target 2019 | Cumulative Achievements until Q3 2019 |
|---|---|---|---|---|---|---|
| | (cross-cutting | **IR-T 1.1** No. of high level meetings/IAG conducted in a year | 3 | 3 | 3 | 3 |
| 1 | 1.1 Routine immunization monitoring to improve coverage and address equity issues | **IR-T 1.1.1** Proportion of national immunization review meetings that discussed concurrent monitoring feedback provided | 75% | 100% (6/6) | 75% | 100% |
| | | **IR-T 1.1.2** Proportion of STFI that discussed concurrent monitoring feedback provided | 75% | 91% (139/153) | 75% | 93% |
| | | **IR-T 1.1.3** Proportion of DTFI that discussed concurrent monitoring feedback provided | 75% | 85% (3374/3960) | 75% | 86% |
| | | **IR-T 1.1.4** Proportion of STFI that discussed Communication updates | 50% | 95% (145/153) | 60% | 93% |
| | | **IR-T 1.1.5** Proportion of DTFI that discussed Communication updates | 50% | 78% (3080/3960) | 60% | 78% |
| | 1.2 Expansion of VPD Surveillance | **IR-T 1.2.1** No. of states where VPD surveillance started | 10 | 8 | 13 | 7 |
| | | **IR-T 1.2.3** Proportion of measles outbreaks investigated as per guidelines | 70% | 59% (1325/2291) | 80% | 59% |
| | | **IR-T 1.2.4** Percent VPD cases investigated by DIOs/ Govt officer | 50% | 95% (3605/3800) | 60% | 95% |
| | 1.3 Introduction of ANMOL to improve data collection and management e.g. availability of real time data, automated due lists for immunization | **IR-T 1.3.1** Percentage registration of infants in RCH portal (intervention states) | tbc | N/A | tbc | NA |
| | | **IR-T 1.3.2** Percent of ANMs reporting data via ANMOL | 30% | 0 | 80% | NA |
| | 1.5 Establish an effective platform for various stakeholders | **IR-T 1.5.1** Proportion of laboratory confirmed cases of CRS | 20% | Expected reporting from Jan | 25% | Expected reporting from Jan |

[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.
Countries are encouraged to highlight in subsequent sections and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

| Objective | Activity | Activity / Indicator description | Annual Target 2018 | Cumulative Achievements 2018 | Annual Target 2019 | Cumulative Achievements until Q3 2019 |
|---|---|---|---|---|---|---|
| | to work together in the area of research and immunization | | | 2019 | | 2019 Expected reporting from Jan 2019 |
| | | **IR-T 1.5.2** Proportion of laboratory confirmed cases of pneumococcal disease | 20% | | 25% | |
| | 1.6 GAVI Secretariat - Project Management Cell (PMC) | **IR-T 1.1** No. of high level meetings/IAG conducted in a year | 3 | 3 | 3 | 3 |
| 2 | 2.1 Capacity building of master trainers for microplanning and RI strengthening | **IR-T 2.1.1** Percent of districts conducted district level trainings after state ToT on MO immunization handbook/ health worker | 60% | 87% (55/63) in four states | 60% | 83% |
| | | **IR-T 2.1.2** Percent of districts conducted district level trainings after state ToT on RI microplanning package | 60% | 89.8% (71/79) in 5 states | 60% | 62% |
| | 2.2 Capacity building of master trainers for microplanning and RI strengthening | **IR-T 2.2.1** % of HR (ANM, MOs, Supervisor etc.) trained in using the developed package for knowledge building and self- learning in the pilot states/districts | 70% | Not applicable as per the timeline | 80% | NA |
| | 2.3 Development of a tribal strategy for immunization programme | **IR-T 2.3.1** Developed strategies for immunization program in tribal areas | n/a | N/A | Yes | Yes |
| | 2.4 Enhancing routine immunization quality and coverage, and addressing inequities in urban areas | **IR-T 2.4.1** No. of cities with RI microplans developed | 5 | 60% (3/5) | 7 | 4 |
| | | **IR-T 2.4.2** Percent of sessions held as per developed urban RI microplans | 60% | 92.4% (4274/4622) | 70% | 91% |
| 3 | 3.1 Capacity development of cold chain and vaccine handlers, technicians and vaccine logistics managers | **IR-T 3.1.1** Percentage of trainees with positive increase in cold chain knowledge score (pre and post assessment) | 80% | 100% | 90% | 100% |
| | | **IR-T 3.1.2** Assessment of technical skills by CCTs for CC Management (Performance assessment study, one time activity) | n/a | N/A | Yes | Yes |
| | 3.2 NCCMIS augmentation and Immunization Supply Chain-Cold Chain data harmonization | **IR-T 3.2.1** Percentage of UNICEF supported HPDs using NCCMIS at least once a month | 60% | 65% | 70% | 76% |
| | 3.3 Support Govt. in review and implementation of EVM Improvement Plans | **IR-T 3.3.1** Percent of States with an Improvement Plan after EVM assessment | 100% | 100% | 100% | 100% |
| | 3.4 Strengthening of Institutions, cold chain infrastructure and equipment | **IR-T 3.4.1** Percent of national review meetings conducted by NCCVMRC discussing immunization supply chain dashboard | 50% | 100% | 100% | 100% |

| Objective | Activity | Activity / Indicator description | Annual Target 2018 | Cumulative Achievements 2018 | Annual Target 2019 | Cumulative Achievements until Q3 2019 |
|---|---|---|---|---|---|---|
| | 3.5 Establish eVIN system infrastructure in the additional new States/UT | **IR-T 3.5.1** No. of states and UTs with eVIN reflected in state PIP | 12 (33%) | 12/12 (100%) | 15 (42%) | 13 (100%) |
| | | **IR-T 3.5.2** No. of states maintaining eVIN adherence rate > 90% | 75% | N/A | 85% | |
| 4 | 4.1 Capacity development of FLWs /providers on SBCC and IPC through training of master trainers | **IR-T 4.1.1** Percent of ANMs and ASHAs trained on RI by Master trainers (focusing on IPC skills in intervention states/districts) | 35% | 18% (414927/2,300,000) | 60% | 42% |
| | 4.2 Communication planning linked with micro planning to reach high-risk/underserved through SBCC cells | **IR-T 4.2.1** Percent of districts with communication plan | 30% | 47% (64/137) | 40% | 52% (94/182) |
| | 4.4 Effective use of Polio Network (SMNet) for routine immunization health systems strengthening | **IR-T 4.4.1** % caregivers told that they received RI session information through Community mobilization coordinators in Underserved areas | 80% | 85% (UP-89, Bihar-75) | 90% | 84% (UP-86%, Bihar-60%), |
| | 4.6 Creating enabling environment for immunization through Policy, Media and Advocacy at the national and state level | **IR-T 4.6.1** Percent of positive media information on RI in English and Hindi print, TV and Radio | 35% | 57%, | 35% | 70% |

**PEF Targeted Country Assistance: Core and Expanded Partners at October 2019** *(to be pre-filled by Gavi Secretariat)*

*NOTE: Figures excl. PSC*

| | Year | Funding (US$) | | | Staff in-post | Milestones met | Comments |
|---|---|---|---|---|---|---|---|
| | | Appr. | Disb. | Util. | | | |
| **TOTAL CORE** | **2018** | **1.96M** | **1.96M** | **1.96M** | **72% (8/11)** | **64% (32/50)** | |
| | **2019** | **1.61M** | **1.21M** | **418K** | **92% (11/12)** | **81% (17/21)** | |
| ***UNICEF*** | 2018 | 877K | 877K | 877K | 66% (6/9) | 100% (9/9) | |
| | 2019 | 877K | 658K | 345K | 90% (11/11) | 100% (3/3) | |
| ***WHO*** | 2018 | 578K | 578K | 574K | 100% (2/2) | 80% (8/10) | |
| | 2019 | 578K | 433K | 74K | 100% (2/2) | 100% (6/6) | |
| ***CDC*** | 2018 | 507K | 507K | -- | -- | 48% (15/31) | |
| | 2019 | 160K | 120K | -- | -- | 66% (8/12) | HPV & TCV activities discontinued |
| **TOTAL EXPAND** | **2018** | **476K** | **577K** | **577K** | **--** | **83% (24/29)** | |
| | **2019** | **613KK** | **49K** | **49K** | **--** | **100% (4/4)** | |
| ***Jhpiego*** | 2018 | 199K | 250K | 250K | 12 team members | 40% (2/5) | |
| | 2019 | 500K | 0K | 0K | -- | 100% (4/4) | HPV activities discontinued |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ***JSI*** | 2018 | 276K | 376K | 376K | 12 team members | 100% (4/4) | Balance brought forward from previous year |
| ***Kantar*** | 2019 | 113K | -- | -- | -- | -- | Vaccine hesitancy research and pilot implementation Phase 1 in progress |

## 3. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

Healthcare in India has always been on priority of Indian Government. There have been several initiatives undertaken by Hon'ble Prime Minister of India to achieve Universal Health Coverage by 2030 in the context of meeting the sustainable development goals. With a view of achieving UHC, the GOI launched Ayushman Bharat (Long Live India) scheme in September 2018 to bring the healthcare services within the reach of the community. Since its inception, within the first year, more than 21,000 Health & Wellness Centres became operational and about 4.7 million people availed treatment under Pradhan Mantri Jan Arogya Yojna (AB-PMJAY). It provided health insurance coverage to the neediest people of the country. It is considered as world's largest government health insurance programme, aimed at providing preventive and promotive healthcare in primary, secondary and tertiary health systems.

Similarly, in 2019, Government of India decided to implement 167 transformative ideas as the 100 day programme of the government, including scale-up of Rotavirus vaccine and strengthening adolescent immunization through Td vaccine. In 2014, Hon'ble Prime Minister Shri Narendra Modi announced the launch of four new vaccines in India's Universal Immunization Programme. Out of these four, Rotavirus vaccine has been the first on the priority list to save children from this deadly diarrheal disease. In 2015, the Hon'ble Prime Minister launched the first indigenously developed and manufactured Rotavirus vaccine. And, in March 2016, India became the first country to introduce Rotavirus vaccine in the national immunization programme in WHO South East Asia region. An unwavering political commitment to overcome every challenge, a seamless public-private partnership, an evidence-informed decision process, and a comprehensive strategy leveraging the strength and support of every stakeholder, including Gavi, contributed to India's success in the in the introduction and rapid scale up of the Rotavirus vaccine in the entire country under UIP.

Further, considering the recommendation of National Technical Advisory Group on Immunization (NTAGI), Government of India has replaced TT (Tetanus toxoid) vaccine with Td (Tetanus & adult Diphtheria) at 10 years (Td10) and 16 years (Td16) of age, as well as, for pregnant women under the Universal Immunization Programme (UIP). Government of India has suggested three strategies for improving Td coverage i.e. through involvement of RBSK program, strengthening existing routine immunization activities and organizing immunization week for Td immunization.

In 2017, Rubella vaccine was introduced in UIP as Measles-Rubella (MR) vaccine to provide protection against congenital birth defects caused by Rubella infection. A total of 323 million children have been vaccinated across the nation till September 2019. Additionally, PCV was also introduced in a phased manner starting from 2017. Nearly 7.5 million doses have been administered till September 2019.

Under the stewardship of the Union Health Minister, Dr Harsh Vardhan, the Government of India is also committed to improve the health of children and pregnant women. After successfully achieving the eradication of diseases like polio, maternal and neonatal tetanus, India is now on a path of attaining full immunization coverage so as to cover the last child through strengthening the routine Immunization Program.

As a testament to the aforementioned commitment, acceleration of the actions to immunize every child, the Intensified Mission Indradhanush (IMI 2.0), is being implemented from December 2019 in the states and UTs. It is an effort to strengthen the routine immunization and make it community-centric through mobilizing communities and dealing with the barriers to vaccination. This drive is based on inter-sectorial participation which is an integral component of the programme. Mission Indradhanush with the unstinted support of state governments has yielded encouraging results in the past. Due to this success, Mission Indradhanush has been recognized as one of the 12 best practices globally and featured in a special

issue of the British Medical Journal[5]. In December 2018, global partners' forum on maternal, neonatal & child health (PMNCH) was held in India, where a coffee table book on 36 best practices was released. The success story of Mission Indradhanush featured in the book, which was appreciated by the Hon'ble Prime Minister during his inaugural speech.

Further, to celebrate Vaccine Heroes around the world from parents and community members to health workers and innovators, World Immunization week was celebrated in the last week of April, 2019 under the theme "Protected Together, #Vaccines Work".

Furthermore, to acknowledge the efforts behind the success of Pulse Polio programme, renew our pledge to reach every child and save them from Vaccine Preventable Disease (VPDs), silver jubilee of Pulse Polio programme was celebrated on 31 October 2019. MoHFW emphasized that efforts will be made to use this experience to reach every new born, drop-out and missed child through a strategic approach involving partnership and greater convergence with other department. Therefore, MoHFW has disseminated an 'Operational guidelines on strengthening immunization system' to the states. The operational guidelines have been disseminated to the States/UTs, outlining key strategies and activities for strengthening the immunization system and sustaining the gains to date.

***Potential future issues (risks)***

MoHFW has identified potential risks to UIP and the risk mitigation actions currently being undertaken (see Table 1).

***Table -1: Potential risks and mitigation actions***

| S. No. | Potential risks | Mitigation actions |
|---|---|---|
| 1. | Lack of management/ implementation capacity due to conflicting priorities | • Mapping of the key activities undergoing/ planned using the immunization calendar<br>• Mapping of key stakeholders and defining their roles and responsibility regarding the new vaccine introduction and HSS<br>• Addressing conflicting priorities through immunization review meetings with partners at the national level |
| 3. | Admin data quality issues | • Data Quality Assessments (DQAs) have been undertaken, as a part of UIP reviews, with development of data quality improvement plan as a part of iCIP.<br>• Use of WHO coverage monitoring charts.<br>• CCEs data from eVIN and NCCMIS are being triangulated and rationalized.<br>• Analysis, feedback and rectification mechanism has been streamlined for AEFI case data from states in HMIS.<br>• Direct entry of case details by districts in to Surveillance and Action for Events following Vaccination (SAFE-VAC) – a web based data tool – has improved the data quality and speed-up the processes of recording and reporting of cases of AEFI. This has fast tracked the response time following AEFI, reduced the data loss and time while transmitting the AEFI data, and strengthened the causality assessment of AEFI cases. |
| 4. | Vaccine Confidence & hesitancy issues | • Vaccine Hesitancy pilot in selected geographies is being implemented by Kantar under Gavi support.<br>• Tailored communication approach for districts with Evidenced based targeted media intervention |

[5] https://timesofindia.indiatimes.com/india/mission-indradhanush-to-feature-in-special-issue-of-british-medical-journal-next-month/articleshow/66991302.cms

## 4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

### 4.1 Coverage and equity of immunisation

As per the concurrent RI monitoring data of WHO, FIC has increased from 64% in 2013 to 82% in 2019 (Jan-Sep 2019) in targeted areas[6]. The percentage of partial and no immunization status in 2013 has decreased from 31% and 5% to 17% and 1% respectively in 2019.

***Figure 1: Proportion of full immunization status, WHO Concurrent RI monitoring, 2013 & 2019****

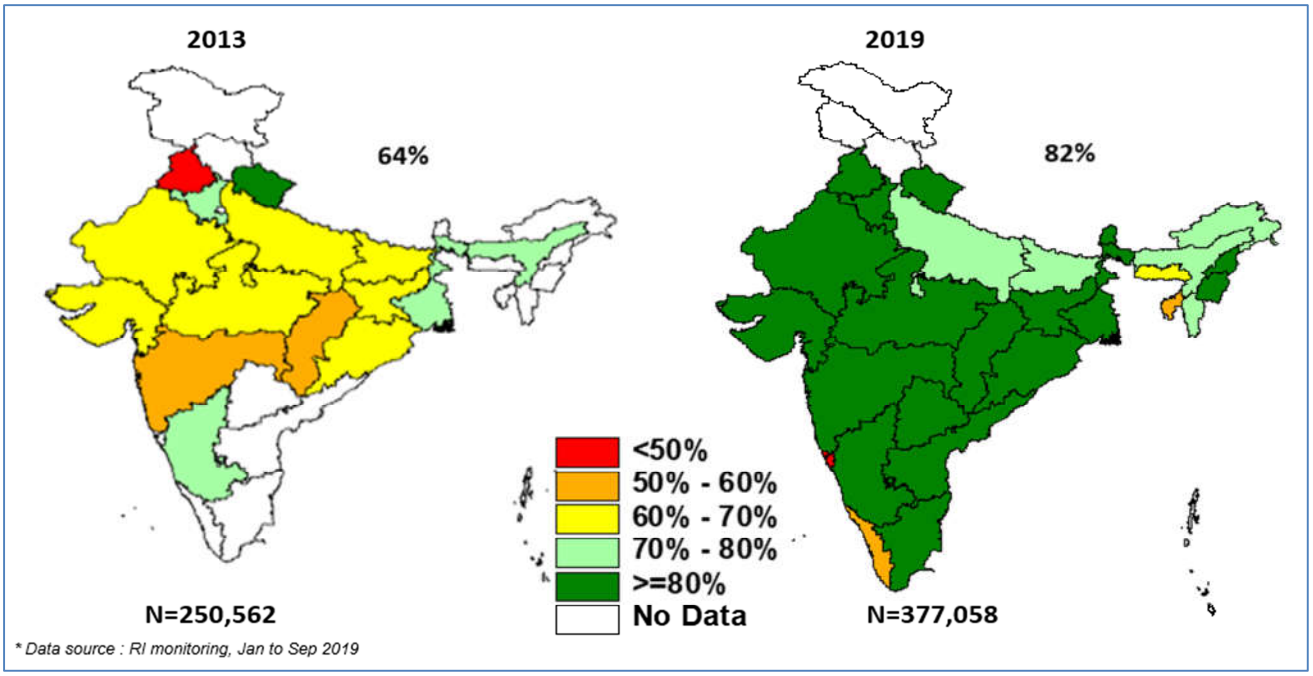
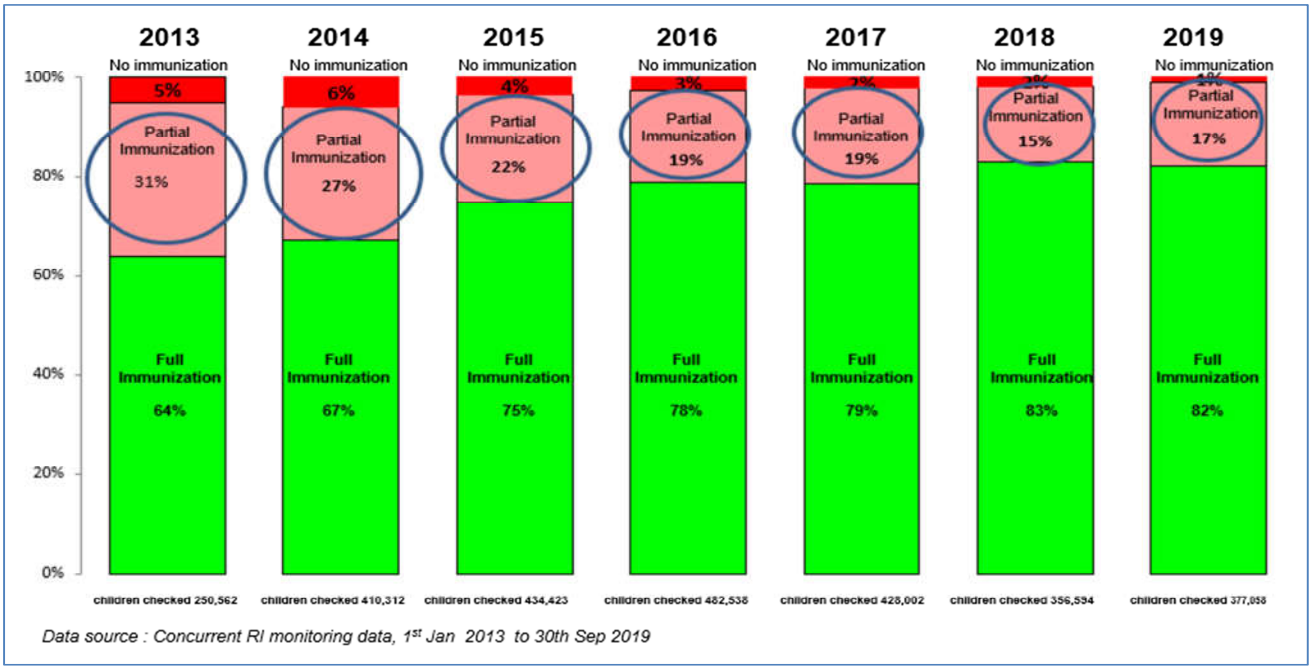


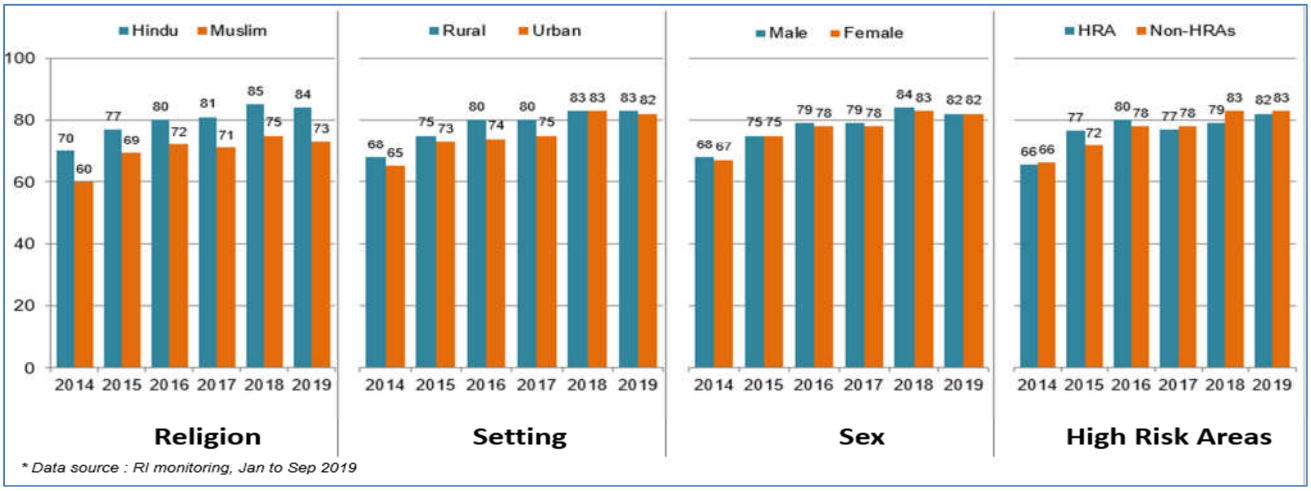

***Figure 2: Proportion of full immunization status, 12-23 months, India, 2013-2019****




[6]The low coverage in the state of Kerala is due to very small sample size from identified low performing pockets

With respect to the equity, WHO concurrent monitoring data shows that the inequity in variables such as high risk areas (HRAs), rural-urban, gender and religion has reduced over the years for full immunization status in 12-23 months.

***Figure 3: Proportion of full immunization status in different settings in 12-23 months, RI monitoring (2014-2019*)***

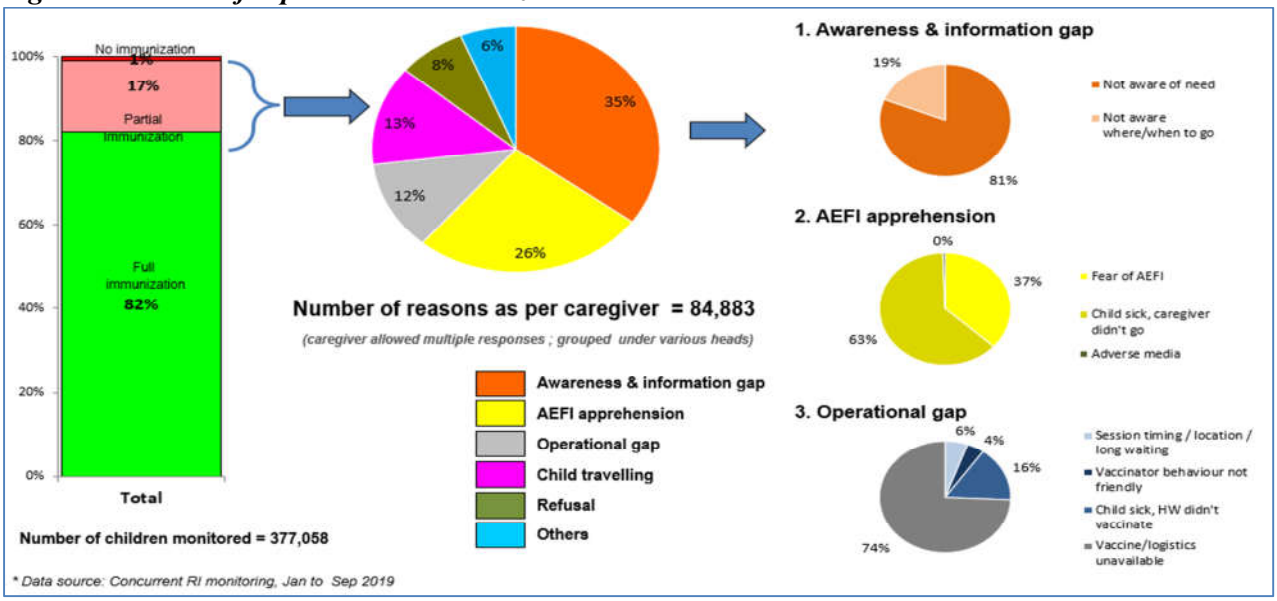



To improve immunization coverage & address inequity issues, Mission Indradhanush was launched in December 2014. Further intensification of Mission Indradhanush has led to an accelerated increase in the full immunization coverage by 1 8.5 percent points. The phase wise coverage under Mission Indradhanush may be seen at **Annexure 9.2.** To follow a strategic direction and work towards sustaining the gains achieved to date, Government of lndia has decided to launch the Intensified Mission Indradhanush (IMI) 2.0 to accelerate the progress towards goals of 90% full immunization coverage in the country.

### 4.2 Key drivers of sustainable coverage and equity

Between January 2018 to September 2019, WHO concurrent monitoring covered over 2.5 million children and 0.36 immunization sessions. Further, the data from January 2019-September 2019 provides trends in immunization coverage and the reasons for partial or no immunization. As per the data, awareness and information gap (35%), AEFI apprehension (26%) and refusal (8%) are the prime reasons for low immunization coverage (Figure 4). Unavailability of vaccines and other logistics at the immunization sites are key contributors to the 12% operational gap cited for partial and no immunization.

***Figure 4: Reasons for partial/ no immunization***



Under Gavi HSS grant, tailored strategies for the urban & tribal population are being developed by involving the Urban Health division of MoHFW & Ministry of Tribal Affair. Low Immunization coverage in tribal population was found as one of the impediments in achieving 90% Full Immunization Coverage (FIC). The two-pronged approach has been adopted to improve the FIC in high populated tribal areas. UNICEF carried out a need assessment study in selected 14 districts of 7 states to support and understand the bottlenecks and challenges related to low immunization coverage among tribal population and identification of opportunities to bridge the gap. In parallel, 15 states with high tribal populations were supported to develop state-specific tribal immunization strategies focusing on customs, practices, and challenges faced by local tribes. Based on wide consultation with various stakeholders, states specific strategies have been developed. Some innovative approaches related to access, demand or behaviour change will be piloted in selected states as part of the strategy while some scale up interventions are being proposed for implementation under the National Health Mission.

For urban population, 14 cities (HSS-14 cities & PEF TCA-4 cities) have been identified based on population, immunization status in urban areas, evidence generated through VPD surveillance etc. WHO-NPSP has been providing oversight in the areas such as Risk prioritization, Microplanning and mapping, Capacity Building (includes MOs; health workers; and community mobilisers), monitoring and supportive supervision, feedback mechanism and supporting task forces etc. and play a catalytic role to intensify efforts of National Urban Health Mission. As a pilot to strengthen urban immunization activities and learn lessons which may later be extended to other urban areas 14 cities identified. With the support of NPSP network, more than 7000 urban personnel have been trained in 14 cities including Medical Officers, Staff Nurses, ANMs, ASHA, link workers and Mahilla Arogya Samitis (MAS). Indicators such as demography, infrastructure, human resources, accountability, and facility wise microplanning details have been mapped and analysed for identification of bottlenecks for further corrective actions. Comprehensive micro-plans have been prepared for most of the planning units and is on-going for rest of the urban facilities. Urban/District task forces are being tracked for quality and frequency of meetings. Close follow up and support is being provided to these 14 cities with the objective of replicating the lessons learnt in all National Urban Health Mission identified cities.

Further, to identify bottlenecks in the urban areas that are likely to delay achievement of 90% FIC and to have an updated urban-specific coverage improvement plan which can be guided by measurable indicators to assess progress, a situational analysis for two selected cities (Rajkot, Jabalpur) were conducted for assessing the current scenario, identifying unique challenges and making need-based intervention plan.

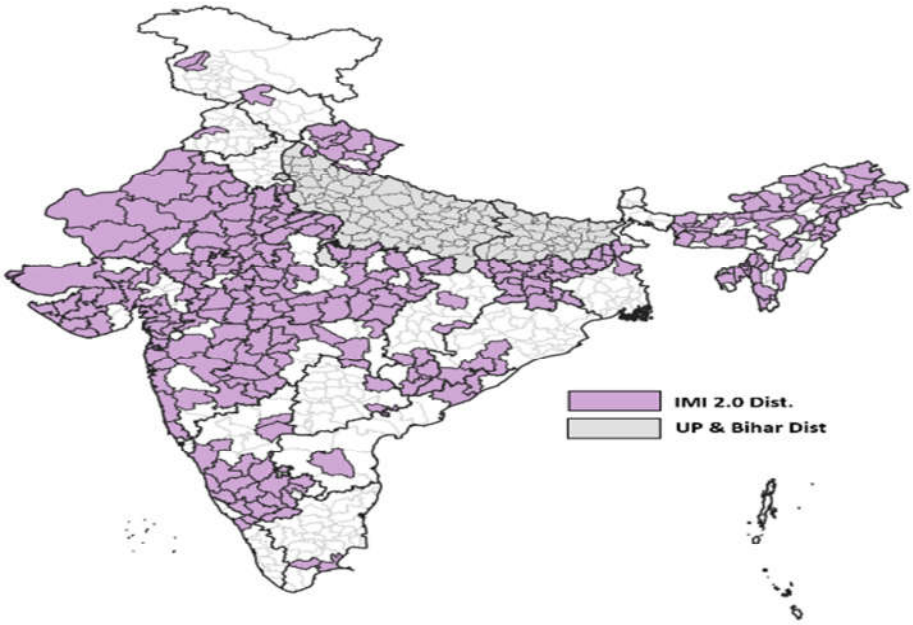
To implement intensified campaigns for boosting coverage in low performing areas and among vulnerable population and sustain the gains achieved so far through strengthening routine immunization systems, MoHFW has planned to conduct the Intensified Mission Indradhanush 2.0 from December 2019 to March 2020. This campaign will cover 271 districts from 27 States/UTs and 652 blocks from 109 districts of UP and Bihar. The districts cities have been selected through triangulation of available datasets such as national surveys, HMIS data and WHO concurrent monitoring and VPD surveillance data.

**Selection criteria for 271 districts**

- State with full immunization coverage (FIC) < 70% based on CES 2018 (unpublished data) - 14 States & UTs
    - All districts < 80% FIC based on survey data (IMI-CES & NFHS 4)
    - All districts < 95% FIC based on HMIS coverage
- Remaining 20 States & UTs with > 70% FIC based on CES 2018 (unpublished data)- except UP & Bihar
    - NPSP VPD surveillance data i.e. Measles incidence more than 10 per lakh population or Diphtheria & Pertussis incidence more than 1 per lakh
    - Aspirational districts FIC < 80% based on IMI CES & NFHS-4

**States & UTs not included in IMI -** Andaman & Nicobar, Chandigarh, Daman & Diu, Goa, Lakshadweep, Pondicherry, and Sikkim.

***Figure5. The map illustrates 271 Districts of 27 States as identified by the government for Intensified Mission Indradhanush.***




In Uttar Pradesh and Bihar, IMI strategy is based on identification of poor performing blocks– total 425 blocks are selected for Uttar Pradesh and 227 for Bihar for IMI 2.0.

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**Criteria for block selection:**

i. FIC < 80% based on concurrent monitoring data

ii. Block with high VPD cases i.e. Measles incidence > 10 per lakh population or Diphtheria/Pertussis incidence > 1 per lakh population

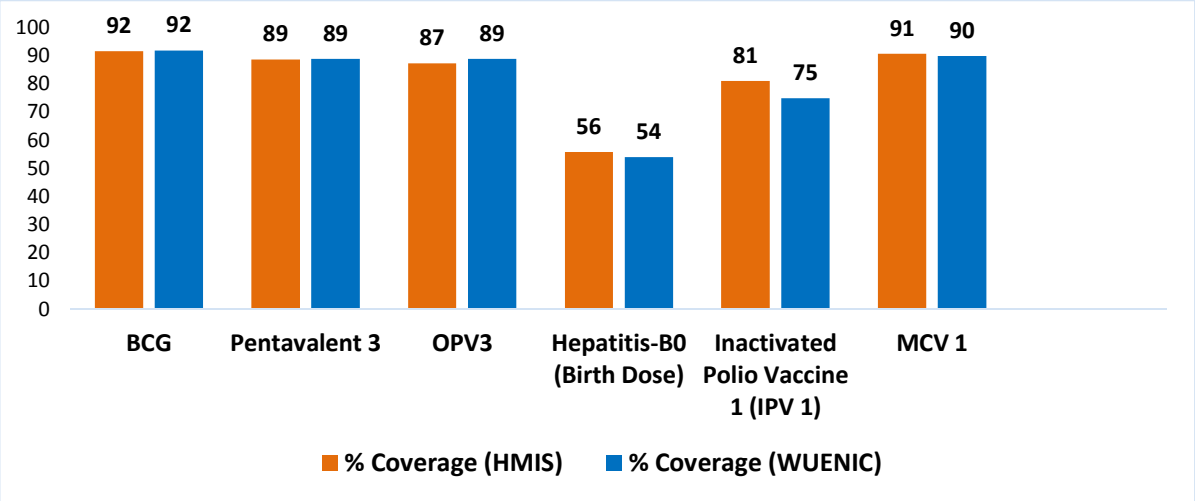
**S**upport is sought in social mobilization of beneficiaries and/or in operational support for effective implementation of IMI 2.0, from following 14 line ministries: Ministry of Defence, Ministry of Jal Shakti, Ministry of Home Affairs, Ministry of Human Resources & Development, Ministry of Housing & Urban Affairs, Ministry of Information & Broadcasting, Ministry of Labour & Employment, Ministry of Minority Affairs, Ministry of Panchayati Raj, Ministry of Railways, Ministry of Rural Development, Ministry of Tribal affairs, Ministry of Women & Child Development and Ministry of Youth Affairs and Sports. A portal has been developed for data entry to track the progress of the activities under IMI 2.0. A dashboard has been developed to give a snapshot of the key indicators under IMI 2.0. The data entry for the portal will be done at the district level for daily reporting. Under IMI 2.0, provision to hire alternate vaccinator, where there is a shortage of ANM, is now being extended to peri-urban and rural areas, in addition to urban areas. IEC activities are planned to be conducted before and during the immunization rounds for increasing demand generation from the beneficiaries. The key highlight of communication strategies for IMI 2.0 includes active involvement of school children for social mobilization and engagement with key influencers (religious leaders etc.).

Four rounds of immunization drives, of seven working days each (excluding Routine Immunization Days, Sundays and Holidays) of IMI 2.0 will be conducted from December 2019 to March 2020. The IMI 2.0 will be followed by system strengthening activities in April 2020. Lessons learnt from IMI 2.0 will be incorporated into Routine Immunization Program which will contribute in overall development for reducing vaccination inequities and ensuring sustainability.

### 4.3 Immunization data

The administrative FIC coverage as reported under Health Management Information System (HMIS) for fiscal year 2019-20 is 87.9% (as on Sep 2019).

***Figure 6: Antigen wise comparison of HMIS (2017-18) and WUENIC 2019***




In India, immunization data is recorded in the RCH registers and tally sheets by the ANMs and consolidated in the form of a monthly report which is submitted to the planning units. Data entry operator uploads the data from the monthly progress report (paper copy) into the HMIS portal. It is of paramount importance that data is of the highest quality, so that it can be used to guide programme actions. The reported immunization data is compared with other sources such as survey, concurrent monitoring or WUENIC and mismatch is taken as an indicator to flag the data quality issues. Although there is minimal mismatch in the HMIS and WUENIC data, there have been data quality issues like significant difference between survey and administrative data, timely availability of data, issues with data completeness and lack of data review for programmatic actions. In order to address data quality issues, Data Quality Assessments (DQA) have been done as part of the comprehensive UIP reviews in five bigger states. To understand and improve the data quality, WHO tool on Data Quality Assessment (DQA) has been adopted to measure the four main parameters- availability, completeness, agreement and consistency between various records. This exercise focused on identifying strengths and weaknesses of the data management and reporting system, assessing the quality of data captured in the immunization records and reports; leading to development of data quality improvement plans. Based on the findings from the assessment, a data quality improvement plan has been developed to maximize the utilization of administrative data for evidence-based planning and management.

Immunization dashboard is a common platform to analyze administrative (HMIS, MCTS/RCH), evaluated and concurrent monitoring data to provide state specific feedback for initiating corrective measures. The dashboards have become a ready reckoner for central and state governments for all data related to routine immunization.

Urban dashboard has been developed based on HMIS data review, an immunization dashboard was developed with an aim to improve quality and use of reported data on immunization to promote programmatic actions for addressing the challenges in strengthening UIP. Dashboards provide state wise performance on various immunization component (timeliness, coverage, VPD cases, etc.) and concurrent feedback regarding reported immunization data to MoHFW, partner organizations and immunization program managers at state level. ITSU in consultation with MoHFW release monthly urban immunization dashboard for the NUHM cities.

In alignment to the roadmap document released by GoI to achieve Full Immunization Coverage, ITSU conducted Comprehensive UIP reviews in 5 states- Bihar, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh. Based on the UIP reviews, Immunization Coverage Improvement Plans (iCIP) were prepared by these states with technical support from ITSU and development partners.

After completing UIP review in the five high priority states, ITSU organized workshops to disseminate the quantitative and qualitative findings of the review to assist the state government and immunization partners to develop an immunization Coverage Improvement Plan (iCIP) for the states. After finalization, the state officials endorsed iCIP and showed their full commitment to actively track the recommended activities under immunization Coverage Improvement Plan (iCIP). Subsequently to support the state, ITSU developed an iCIP tracking tool in consultation with partners to track the key indicators of iCIP. The states share the desired information in excel tool for iCIP to Immunization Division, MoHFW through ITSU and quarterly reports are generated to track the progress. Based on this information, indicator wise report is generated to review the follow up action. The indicator wise report can be viewed by the state online through iCIP Google tool based on the ID provided to the state.

To strengthen the efforts towards this goal, it is imperative to identify the gaps so that tailor-made plans can be developed by all states/UTs on similar lines. The self-assessment activity is also an integral part of the system strengthening and is advocated as an important component in IMI 2.0 operational guidelines.

In this regard, district and block self-assessment checklists have been developed to assess the gaps in immunization programme in a methodological way covering the thematic areas of Programme Implementation, logistics and supply chain, data recording and reporting, programme communication. National ToTs have been organised for creating a pool of master trainers for onward training and conducting self-assessment activity at respective states. To ease up the process of gathering information, a user-friendly mobile-based application has been developed for recording data. Based on the gap analysis, districts have to prepare their immunization Coverage Improvement Plan (iCIP). The states/UTs officials have to track the development and implementation of iCIP prepared by the districts. MoHFW through ITSU is tracking the Self-Assessment activity and development of iCIP from states.

**Vaccine Preventable Disease Surveillance Data**

The cMYP 2018-22 highlights the existing different surveillance systems in India. The plan document highlights various strategies to increase the robustness of VPD system in India such as assessing VPD burden, enhancing the coordination between different sources, involvement of private sector and strengthening the sentinel surveillance for new antigens.

Using the platform of polio and measles surveillance systems, WHO NPSP in concurrence with the GoI designed laboratory-supported surveillance for diphtheria, pertussis and neonatal tetanus. The NPSP provided technical support for establishing a functional laboratory supported surveillance system for VPDs. Their primary functions have been capacity building of health care providers/surveillance staff, monitoring and evaluation of the key components of surveillance, data analysis and providing feedback so that the information generated is used locally to guide the control measures and strengthen the evolving system.

A VPD laboratory network, comprising of seven laboratories across the country with Christian Medical College (CMC) Vellore as the reference laboratory, has been established by providing support for system strengthening, capacity building and logistics. Hands-on trainings of personnel from these laboratories in diagnosis of diphtheria and pertussis were conducted with support from Public Health England and Centers for Disease Control Atlanta, respectively. Cascaded capacity-building workshops using the VPD surveillance field guide conducted for health care providers from both public and private sector for effective implementation of VPD surveillance.

Laboratory-supported VPD surveillance for diphtheria, pertussis and neonatal tetanus is currently functional in twelve states—Bihar, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Uttar Pradesh and Uttarakhand.

During 2016-2019 (till Oct), 7169 diphtheria cases, 4621 pertussis cases and 243 neonatal tetanus cases have been reported. The data being captured is representative of only a few states that have initiated the surveillance system. Areas reporting VPDs are being targeted for special immunization drives under Mission Indradhanush. The data has helped district and state to take targeted actions both in terms of case management and public health intervention in response to case identification.

*Table 2: State wise reported cases of DP & NT 2016-2019.*

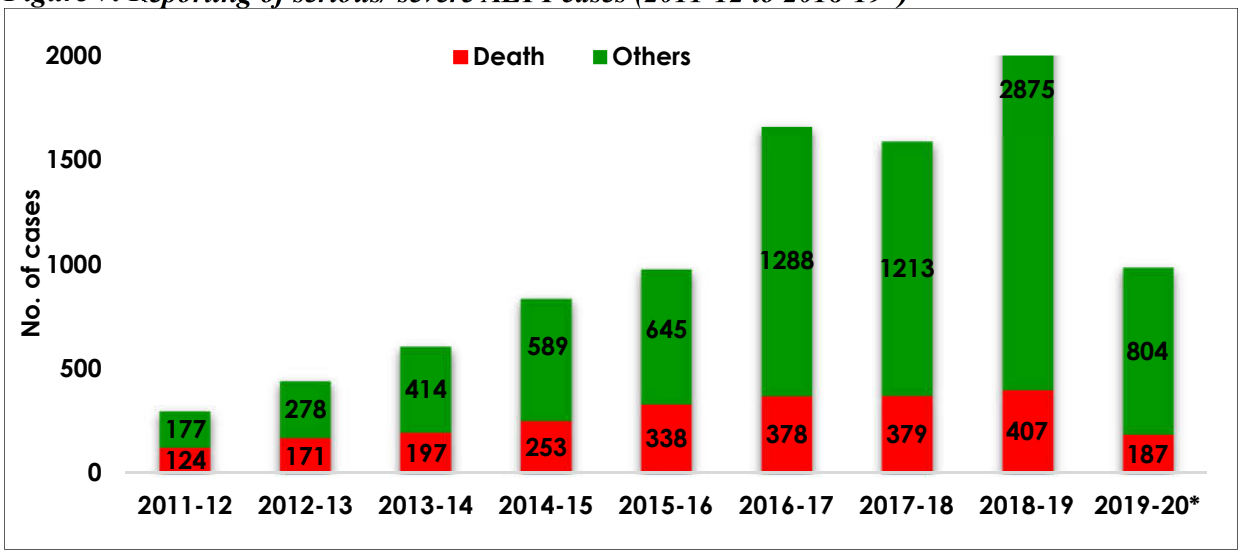
| State | 2016 | | | 2017 | | | 2018 | | | 2019 (Jan - Oct) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # Diphtheria | # Pertussis | # Neonatal Tetanus | # Diphtheria | # Pertussis | # Neonatal Tetanus | # Diphtheria | # Pertussis | # Neonatal Tetanus | # Diphtheria | # Pertussis | # Neonatal Tetanus |
| BIHAR | 45 | 38 | 15 | 55 | 110 | 13 | 82 | 150 | 10 | 60 | 63 | 12 |
| GUJARAT | | | | | | | | | | 110 | 36 | 14 |
| HARYANA | 69 | 76 | 3 | 46 | 68 | 3 | 240 | 81 | 3 | 203 | 48 | 2 |
| HIMACHAL PRADESH | | | | | | | 0 | 7 | 0 | 2 | 3 | 0 |
| JHARKHAND | | | | | | | | | | 7 | 9 | 5 |
| KARNATAKA | | | | | | | 27 | 2 | 0 | 566 | 41 | 0 |
| KERALA | 560 | 84 | 0 | 602 | 93 | 0 | 321 | 179 | 0 | 232 | 113 | 0 |
| MADHYA PRADESH | | | | 66 | 38 | 14 | 87 | 180 | 11 | 72 | 70 | 19 |
| MAHARASHTRA | | | | | | | | | | 71 | 19 | 1 |
| PUNJAB | | | | | | | 9 | 55 | 1 | 12 | 24 | 0 |
| UTTAR PRADESH | 727 | 101 | 34 | 847 | 1378 | 30 | 1310 | 1350 | 28 | 690 | 192 | 25 |
| UTTARAKHAND | | | | | | | | | | 51 | 13 | 0 |
| TOTAL (12 states) | 1401 | 299 | 52 | 1616 | 1687 | 60 | 2076 | 2004 | 53 | 2076 | 631 | 78 |

## Vaccine safety data

The AEFI Secretariat manages the AEFI surveillance programme and coordinates with various stakeholders in vaccine safety. The AEFI Secretariat is quality certified as per National Quality Assurance Standards for national level AEFI surveillance processes. WHO assessed the National Regulatory Authority (including AEFI Secretariat and Immunization Division) and gave a maturity rating of 4 which is the highest possible rating. **Annexure 9.3** shows the key achievements under AEFI surveillance.

**Surveillance and Action For Events following Vaccination (SAFE-VAC)** is a web-based tool developed to digitize data related to reporting and investigation of serious / severe AEFI cases. There is a plan to integrate SAFE-VAC with RCH portal of MoHFW for minor AEFIs after the complete operationalization of SAFE-VAC in all states/UTs. The software, piloted in Madhya Pradesh and West Bengal in 2016, was upgraded in 2017 before two national level trainings were conducted in 2018. Representatives from all states have been trained in reporting of serious/severe AEFI cases. 25 states have already initiated reporting of cases in 2019. It is expected that all AEFIs will be reporting on the SAFE-VAC by December 31, 2019.

*Figure 7: Reporting of serious/ severe AEFI cases (2011-12 to 2018-19*)*

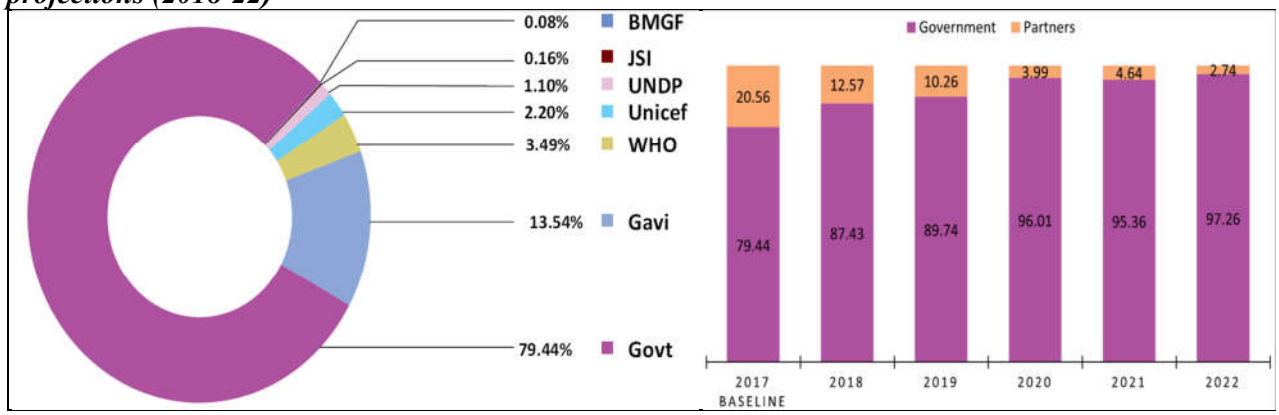



*(* data as on 30 Sep 2019)*

### 4.4 Immunisation financing

The immunisation expenditure in 2017-2018 (including shared personnel costs) is estimated to be over US$ 1 billion, to which GoI funded 79% (cMYP 2018-22). GoI contribution will increase as Gavi support scales down. As projected under cMYP 2018-22, the share of GoI contribution will increase from 79% in 2017 to 97% in 2022.

***Figure 8: Contribution of GoI and partners in total expenditure (%): Baseline expenditure (2017) and projections (2018-22)****




** The contribution of 13.5% from Gavi includes vaccines only. The contribution of WHO, UNICEF, UNDP and JSI include their respective portions of the Gavi HSS grant.*

## 5. PERFORMANCE OF GAVI SUPPORT

### 5.1 Performance of Gavi HSS support (if country is receiving Gavi HSS support)

The HSS 2 (2017-21) support started in Q4 of 2017, after the grant approval in July 2017 followed by MoU development and disbursements. Table 3 below shows selected results from the HSS 2 support. The Grant Performance Framework table on Pg. 2 shows the details of the Intermediate results/tailored output indicators by objective area.

***Table 3: Targets and Achievements of selected core and tailored Grant Performance Indicators:***

| PF Indicator Number | Indicator | Annual Target 2018 | Cumulative Achievements in 2018 (with respect to targets) | Annual Target 2019 | Cumulative Achievements till Q3 2019 |
|---|---|---|---|---|---|
| OI-T 1 | Full immunization coverage (%) | NA | NA | NA | NA |
| OI-T 2 | No. of states/UTs with Sickness rate maintained within 2% | 28 | 25 | 32 | 29 |
| OI-T 3 | Percent districts in a state reporting VPD data | 60% | 98.3% (8 states) | 70% | 97.7% (12 states) |
| OI-T 4 | % of CCP with vaccine availability index more than 90% (aggregated by States) | 50% | 91.7% | 80% | 94.1% |
| OI-T 5 | Reduction in temperature breach of CCEs (aggregated by States) | 20% | 39% | 40% | 40% |
| IR-C 3.0 | Effective Vaccine Management Score (composite score) | 65% | 68% | NA | NA |
| IR-C 4.1 | Percentage point difference between Penta 3 national administrative coverage and survey point estimate | NA | NA | NA | NA |

The third year (2019) of implementation of the HSS 2 support is progressing well, with delays in some activities due to competing priorities in the immunisation programme. Table 4 shows a summary of the programmatic and financial performance by objective area. Detailed progress by activity has been shared in the quarterly reports to Gavi.

***Table 4: Objective wise summary performance of Gavi HSS 2 in Q3 2019***

| **Objective 1** | |
|---|---|
| **Objective of the HSS grant** | To strengthen and maintain robust data systems to improve evidence based decision making |
| **Priority geographies/population groups or constraints to C&E addressed by the objective** | Refer to annexure 9.4 |
| **% budget utilisation** | 82% |
| **Major activities implemented & Review of implementation progress** | • Till date, in 2019, 2 meeting of Immunization Action Group (IAG) conducted under chair-ship of JS (RCH) to review the progress of Gavi supported activities.<br>• Concurrent monitoring feedback discussed in 100% of the STFI meetings and in 91% of the DTFI meetings; Communications updates discussed in 100% of the STFI meetings and in 81% of the DTFI meetings.<br>• State-level VPD surveillance workshop conducted in Chhattisgarh and Tamil Nadu during Jul-Sep 2019.<br>• Cases reported from VPD surveillance states during Jul-Sep'19: Diphtheria: 950; Pertussis: 84 and Neonatal Tetanus: 35<br>• About 44% (21/48) flagged suspected measles outbreaks investigated in the period of Jul-Sep 2019.<br>• Coverage Evaluation Survey (CES): National and state level factsheet data submitted to MoHFW. Draft national report submitted to statistic division for review. Feasibility study for Health Records under process and will be completed by 31st October 2019<br>• HSS-2 baseline assessment completed and the approved report was shared with Gavi |
| **Major activities planned for upcoming period and needs for technical assistance** | Refer annexure 9.4 on 2019 work plan; no change in activities planned |
| **Objective 2:** | |
| **Objective of the HSS grant** | To improve service delivery through improved capacity of human resources |
| **Priority geographies / population groups or constraints to C&E addressed by the objective** | Refer to annexure 9.4 |
| **% budget utilisation** | 67% |
| **Major activities implemented & Review of implementation progress** | • 8 states completed MO Handbbok ToT and 10 states completed Health Worker Handbook ToT<br>• 7 states conducted ToT on RI microplanning package.<br>• RISE package modules are almost complete and ready for roll out from National level.<br>• Tribal Immunization: Tribal Immunization Need Assessment Study conducted in collaboration with NIHFW to understand the bottlenecks and challenges related to low immunization coverage among tribal population and identification of opportunities to bridge the gap. Data collection completed through two rounds of intensive field exercise. Data analysis and report preparation under process. 15 States with high tribal population are currently in the process of developing state specific tribal strategy. States will prioritize planned strategies leveraging funds under PIP, state and other local available resources.<br>• Urban Immunization: Workshops on strengthening of microplans for Medical Officers conducted in all 14 cities; Cascade training for ANMs |

| | |
|---|---|
| | and Staff Nurses conducted in all 14 cities; Trainings of supervisors, Anganwari workers, cold chain handler, and mobilisers conducted as per the need in the urban city. |
| **Major activities planned for upcoming period and needs for technical assistance** | Refer annexure 9.4 on 2019 workplan; no change in activities planned |
| **Objective 3:** | |
| **Objective of the HSS grant** (as per the HSS proposals or PSR) | To strengthen cold chain and Vaccine logistics systems |
| **Priority geographies / population groups or constraints to C&E addressed by the objective** | Refer to annexure 9.4 |
| **% budget utilisation** | 63% |
| **Major activities implemented & Review of implementation progress** | • **eVIN:**<br>o eVIN is currently operational across 100% of 19 states and 2 union territories (Phase-I states - Assam, Bihar, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Manipur, Nagaland, Odisha, Rajasthan, Uttar Pradesh) (Phase-II states - Andhra Pradesh, Dadra Nagar Haveli, Daman and Diu, Goa, Himachal Pradesh, Karnataka, Maharashtra, Telangana, Tripura and Uttarakhand). In states of Arunachal Pradesh, Haryana, Puducherry, Punjab, Kerala and Tamil Nadu, eVIN rollout is currently underway.<br>o eVIN has enabled digitization of the cold chain temperatures, vaccine stocks and flows, and have ensured real-time data availability at nearly 20,252 cold chain points, across 521 districts. eVIN built capacity of 35,719 Vaccine Store Keepers through 911 batches of training. More than 15,000 data loggers have been installed for real time remote temperature monitoring of cold chain equipment. Over 4.08 million transactions are being made on eVIN every month capturing vaccine issues, receipts, discards and transfers.<br>o All the 12 eVIN implementing states of HSS-I have included cost of eVIN in their respective National Health Mission (NHM) Project Implementation Plans (PIPs) for financial year 2019-20<br>o As on October 2019, eVIN dashboard reflects that-<br>▪ nearly 96% cold chain points in eVIN states have vaccine availability index of more than 90% (% of cold chain points which have vaccine availability for more than 27 days in a month)<br>▪ average stock out duration at CCP is 5.2 days<br>▪ average replenishment response time (time between reaching the re-order point and replenishment) is 11.4 days<br>▪ more than 83.9% of cold chain equipment (where data loggers are installed) remain in working status for 90% of time or more in a month<br>• **NCCMIS:**<br>o NCCMIS application with all new features including Supportive Supervision for Immunization (S4I), Immunization Training Management System (iTMIS), spare parts module completed security audit and other 13 parameters as per Government guidelines. Training of States on use of NCCMIS, S4I dashboard and mobile application done in West Bengal, Himachal Pradesh, Rajasthan, Jharkhand, Bihar, Madhya Pradesh, Chhattisgarh, Jammu, Mizoram, Nagaland, Tripura and Rajasthan.<br>• **EVM:**<br>o State EVM assessment for Odisha, Gujarat, Rajasthan, Maharashtra and Bihar completed. Improvement plan (IP) developed for Odisha, Gujarat and Maharashtra. IP development |

| | |
|---|---|
| | under process for Rajasthan and Bihar. EVM planned in November 2019-Kerala. Discussion ongoing with States for planning of EVM assessment- Andhra Pradesh, Tamil Nadu, Assam |
| **Major activities planned for upcoming period and needs for technical assistance** | Refer annexure 9.4 on 2019 workplan; no change in activities planned |
| **Objective 4:** | |
| **Objective of the HSS grant** | To improve demand generation for immunization services to improve coverage and address inequities |
| **Priority geographies / population groups or constraints to C&E addressed by the objective** | Refer to annexure 9.4 |
| **% budget utilisation** | 82% |
| **Major activities implemented & Review of implementation progress** | • **BRIDGE IPC Training:**<br>o 7125 master trainers trained and total no of FLWs trained (ANM+ASHA+AWW): 967951<br>o State Review Meetings for BRIDGE conducted in 16 states<br>o ToR for BRIDGE assessment developed and published. Assessment expected to begin by Mid October 2019.<br>• **SBCC Cell:**<br>o 7 (MP, UP, West Bengal, AP, Jharkand, Bihar, Assam) out of 9 States established SBCC cells with focus on RI. 2 more states, Maharashtra and Gujarat initiated the process.<br>• **CSO/CBO Engagement**:<br>o VHAI and AIH have recruited national and state/district level staff, Identification of State level NGOs is underway, orientation process of staff for RI demand generation and engaging with CBOs/SHGs has been initiated |
| **Major activities planned for upcoming period and needs for technical assistance** | Refer annexure 9.4 on 2020 workplan |

## 5.2 Performance of vaccine support

### a. PCV

On 13 May 2017, the GoI introduced PCV through a phased rollout, with the catalytic support from Gavi.

PCV vaccine introduced in routine immunization in entire Bihar, Himachal Pradesh, Madhya Pradesh, 12 districts of Uttar Pradesh and 9 districts of Rajasthan. Haryana has launched PCV vaccine as a state initiative. In 2019, PCV was further expanded to cover 9 districts in Rajasthan and 7 districts in Uttar Pradesh. Since introduction, nearly 7.5 million doses have been administered in above mentioned districts till September, 2019.

Based on the analysis of PCV reported data, first and second dose of PCV coverage is approx. 10% range of corresponding pentavalent dose. State wise coverage as on Sep-19 is tabulated below.

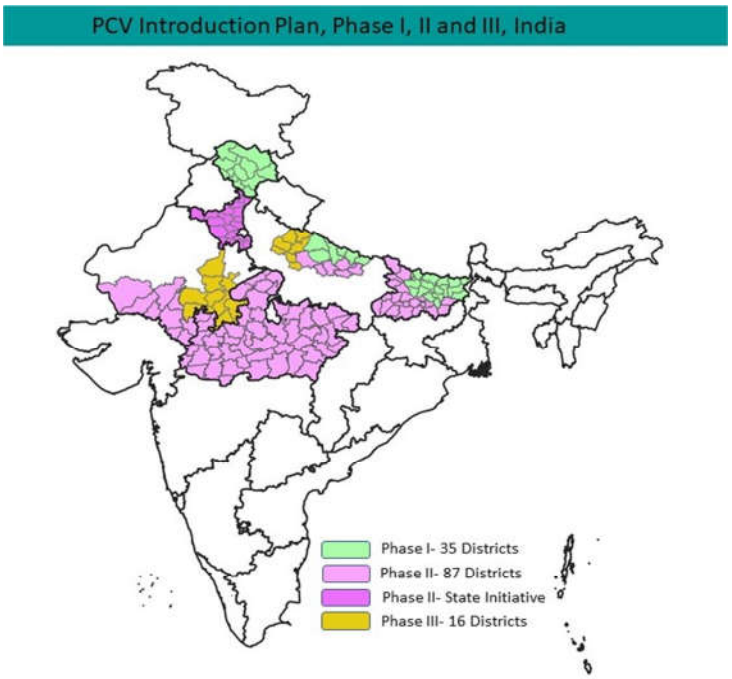


*Table 5: State-wise PCV coverage*

| S.No. | State | Phase | No. of districts covered | Annualized coverage for 2019-20 (in %) | | |
|---|---|---|---|---|---|---|
| | | | | PCV1 | PCV2 | PCV B |
| 1 | Bihar | Complete | 38 | 76 | 78 | 65 |
| 2 | Himachal Pradesh | Complete | 12 | 84 | 84 | 91 |
| 3 | Uttar Pradesh | Phase 1 | 6 | 77 | 67 | 58 |
| | | Phase 2 | 6 | 74 | 71 | 50 |
| | | Phase 3 | 7 | 77 | 39 | NA |
| 4 | Rajasthan | Phase 1 | 9 | 66 | 64 | 61 |
| | | Phase 3 | 9 | 43 | 32 | NA |
| 5 | Madhya Pradesh | Complete | 51 | 64 | 61 | 59 |
| 6 | Haryana | State Initiative | 15 | 80 | 76 | 66 |
| | | State Initiative | 6 | 81 | 76 | 75 |
| **Total** | | | **159** | **71** | **69** | **62** |

**b. Rotavirus vaccine**

In 2016, India became the first country in the WHO-South East Asian region to launch a Rotavirus vaccine developed indigenously, by Indian scientists and manufactured by an Indian producer. In 2019, India becomes the first country in the region to scale-up the Rotavirus vaccine nationally across 29 states and 8 union territories, with domestic funding. Gavi came forward to support the vaccine cost in one state, Uttar Pradesh in 2018. Through the ambitious "100-days agenda", the government expanded the Rotavirus vaccine to all states and union territories between July and September 2019. Currently, India produces two WHO-prequalified Rotavirus vaccines. At less than a dollar-a-dose, these vaccines have become game-changers in India's efforts to reduce under-five mortality in India and beyond.

In 2019, the government has achieved an unprecedented speed in scaling up Rotavirus vaccine to 26 remaining states and union territories in just one hundred days, ensuring access of Rotavirus vaccine to a total of 26.7 million infants.

| Phase | Number of states/UTs introduced | Cohort covered |
|---|---|---|
| Phase 1 (2016) | 4 | 2.4 million |
| Phase 2 (2017) | 5 | 5.6 million |
| Phase 3 (2018) | 2 | 6.6 million |
| Phase 4 (2019) | 26 | 12.1 million |

A four-tier cascade training model was followed, wherein respective health representatives were trained at the national level followed by trainings at state, district and block levels. The trainings were customized to the two vaccines, the Rotavac and the Rotasiil, used under the programme. Immunization experts from fourteen partner organizations, along with the government counterparts trained about 5,000 master trainers who in turn trained more than 43,700 medical officers, ~28,000 cold chain handlers, ~275,000 ANMs, ~886,000 ASHAs and ~10,00,000 AWWs, in about 11,000 training sessions. Senior central government officials and partners support the states and districts in planning the trainings, sensitizing the health officials, and monitoring the quality of session delivery. Innovative adult learning approaches are followed, including a "station approach" for intense small group interactive, hands-on learning.

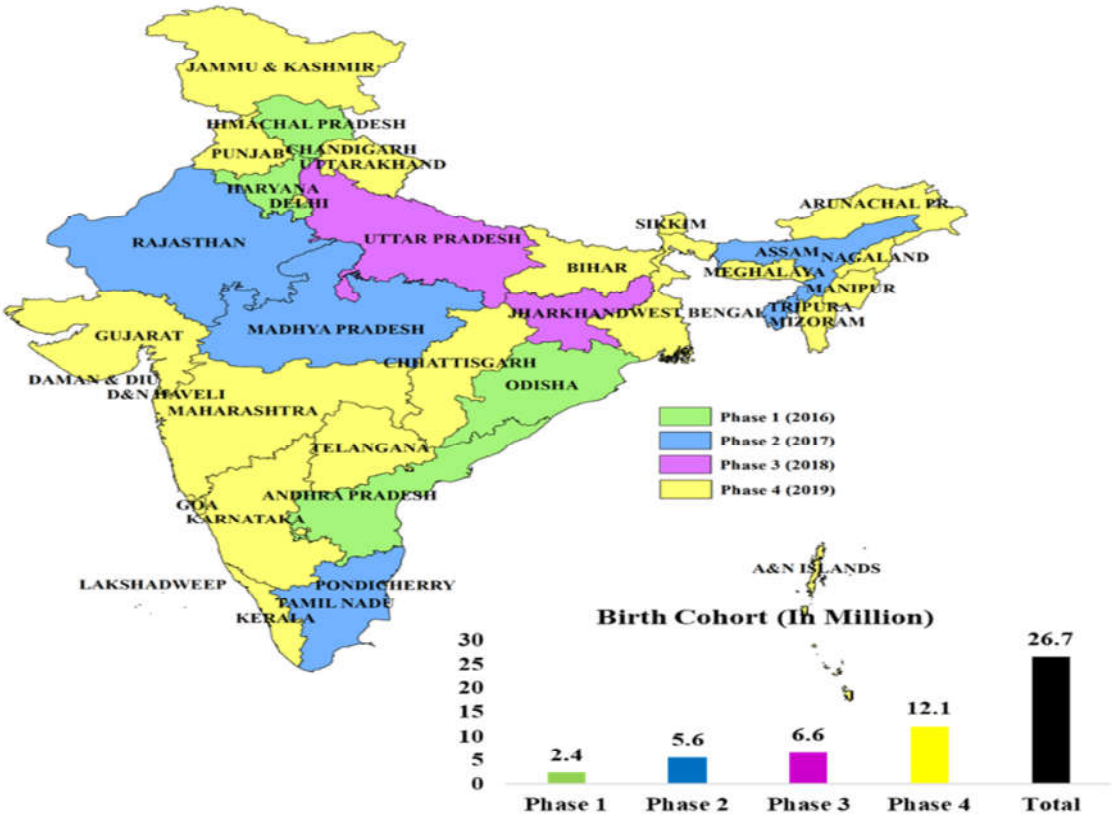
As part of the integrated communication strategy, a 360 degree approach is taken to highlight the need, value and safety of the Rotavirus vaccine, using both electronic and print medium, including banners,

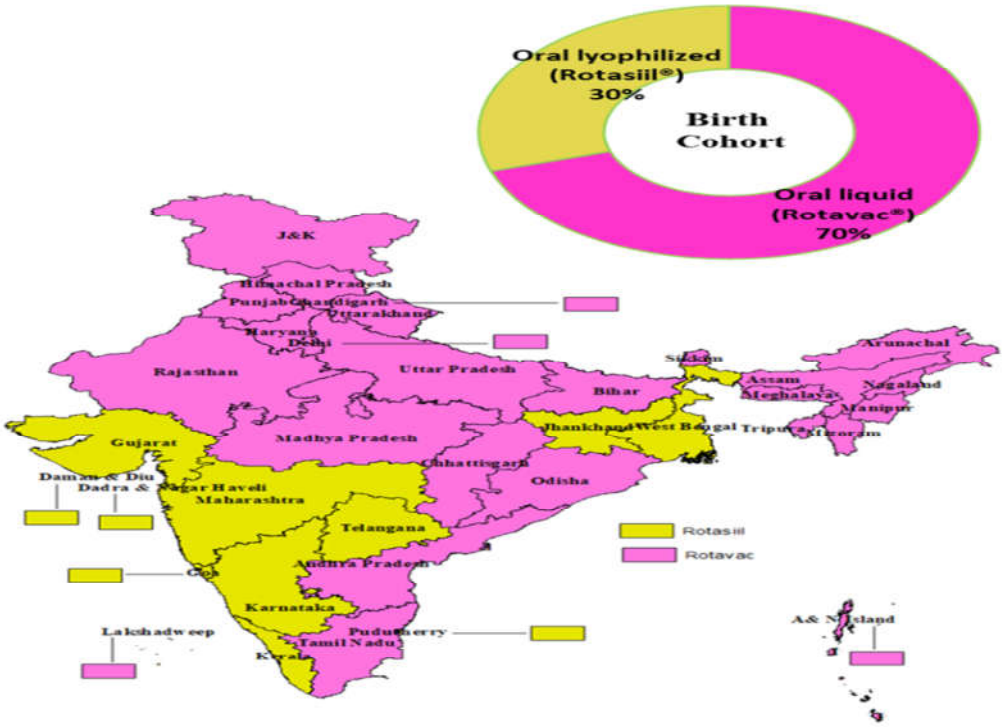
posters, leaflets, audiovisuals and radio jingles. These were developed in fourteen regional languages. Mass and mid media were extensively used for informing the community of the benefits of Rotavirus vaccine as the specific intervention to prevent Rotavirus diarrhoea within the holistic health messaging of diarrhoea control including hand washing. Media sensitization workshops were organized, and state specific media kits were distributed, prior to the launch of the vaccines. The trainings and launch of the programme were extensively covered in national and regional print, electronic and social media helping adoption of the vaccine in the community. Separate training material packages were designed for every cadre and relevant guidelines, leaflets, were disseminated to introduce trainees to the Rotavirus Vaccine.

After the launch of the vaccine, intensive field monitoring was undertaken by the supervising health officials and representatives from partner agencies, using a standard checklist and a GPS-enabled mobile application for the Cold Chain Points and the immunization session sites.

State and district task forces at their respective levels continue to act with the mandate to convene periodically to discuss the progress, and prepare action points on the way forward to address any challenges emerging during the implementation of activities necessary for effective vaccine introduction.

India, for the first time, introduced two Rotavirus vaccine products manufactured by two Indian companies, under the Universal Immunization Programme. Out of thirty-seven states and union territories, twenty-six are using Rotavac and eleven are using Rotasiil. This mixed product use leads to the possibility that children migrating from one state to another may need to be vaccinated with different products to complete their Rotavirus vaccination series at 6, 10 and 14 weeks of age. This programme necessity drives the government to review global evidence on interchangeability of Rotavirus vaccines, and based on the available evidence, interchangeable use of Rotavac and Rotasiil has been allowed in the programme.



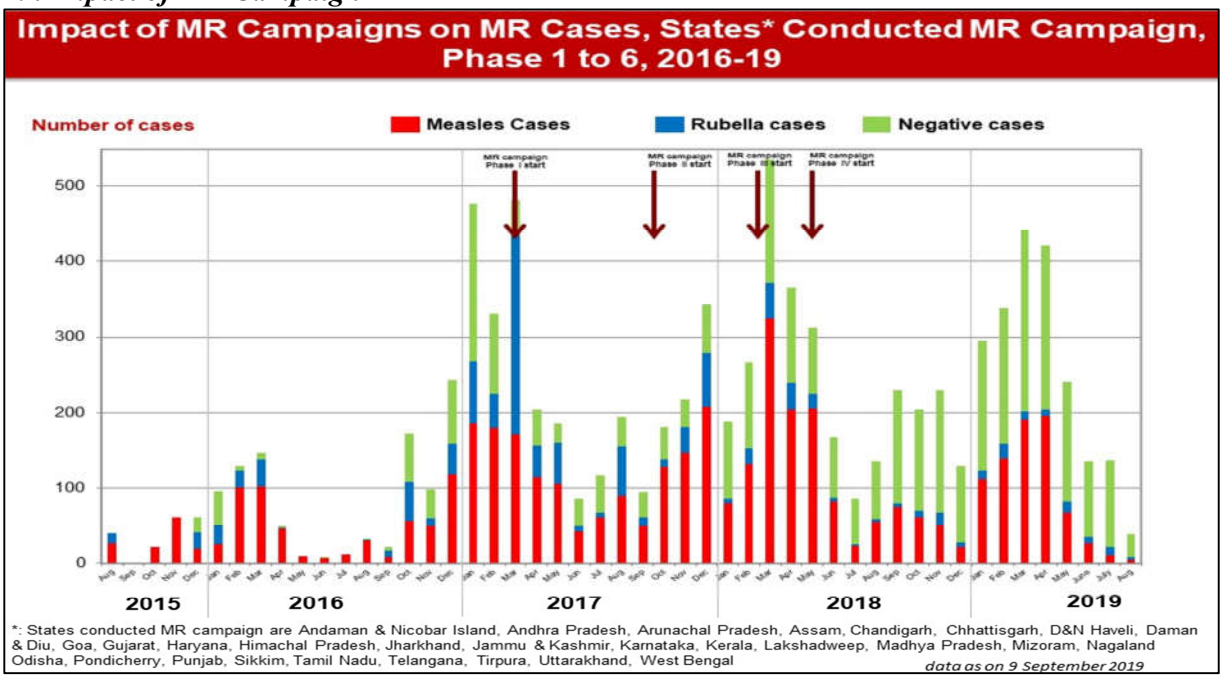



**c. Measles Rubella**

India started the world's largest MR campaign in February 2017, targeting over 400 million children. As of 14 November 2019, MR campaign has been completed in 33 state/UTs and is on-going in 1 state, where 324 million children have been vaccinated with total administrative coverage of 97.24%. **Annexure 9.5** shows the state-wise coverage of the MR campaign.

An impact assessment of MR campaign on routine immunization and overall health system strengthening indicates a significant reduction in the number of measles and rubella cases. Subsequent to the conduct of MR campaign there has been a significant decline in the number of measles and rubella cases as seen in Figure 10.

***Figure –9: Impact of MR Campaign***



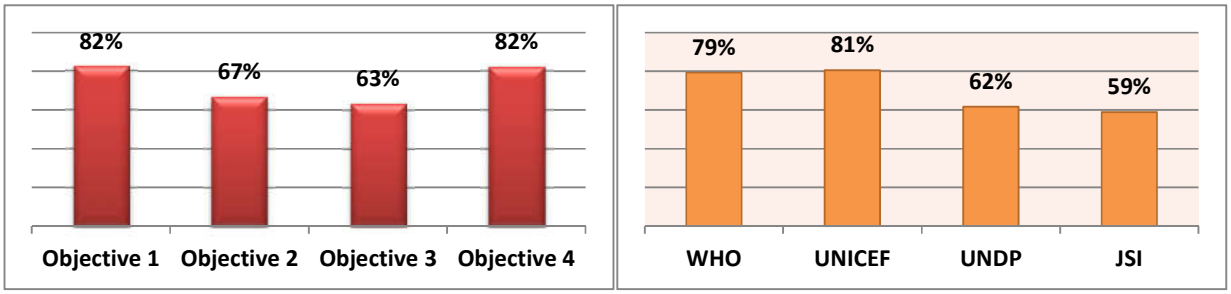
**5.3 Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)**

*Not Applicable*

**5.4 Financial management performance**

USD 45.38 million (~72%) has been spent out of total USD 63.22 million approved for 2017 , 2018 & 2019. The implementation of HSS 2 activities started in Q4 of 2017 due to late approval and disbursement of funds to the respective implementing partners. The funding for Gavi HSS-2 is given to implementation partners (WHO, UNICEF, UNDP and JSI). The cash utilisation is reported in the quarterly reports.

***Figure 10: Objective and agency wise financial utilization (in %) till Q3 2019 of Gavi HSS 2***




*Note: Objective wise utilization does not include programme support cost (PSC), whereas agency wise utilization includes PSC.*

The financial utilization for JSI is quite low because the major payments under RISE project to two agencies engaged for the development of content & IT platform got delayed and the same payments have been done in quarter 4 of 2019. With respect to low funds utilization by UNDP, the current year tranche came very late in the month of August.

**5.5 Transition plan monitoring (applicable if country is in accelerated transition phase)**

GoI takes significant ownership of its immunisation programme. Since 2016, GoI has transitioned (or started to transition) support for pentavalent, IPV, rotavirus and MR vaccines, as well as selected HSS-supported interventions including the polio network and eVIN (see below for further information). Domestic financing of these Gavi-supported vaccines and HSS interventions has more than tripled from $90 million in 2016/17 to 270 million in 2018/19. Many HSS activities are also designed in a cost-sharing modality with GoI to ensure sustainable programming after Gavi support ends.

**WHO – NPSP Transition** [7]

In alignment with the Global Polio Eradication Initiative (GPEI) Strategic Plan, transition is underway for India's polio programme. India has not detected a single case of wild polio virus since January 2011, and on 27 March 2014, the country was officially declared polio-free. The National Polio Surveillance Project (NPSP) played a critical role in achieving and maintaining India's polio-free status. NPSP developed an extensive network of human resources, infrastructure and support to GoI at the union, state and sub-state levels. While initially focused exclusively on polio eradication, NPSP has gradually expanded its activities to include support for routine immunization (RI), measles elimination, rubella and congenital rubella syndrome (CRS) control and multiple other public health initiatives. The opportunities that India's polio-free status presents to accelerate progress in priority areas of work, alongside practical financial considerations (including the phase out of GPEI funding in 2019) and a desire to ensure that prior global investments are appropriately utilized provide a clear rationale for transition planning.

India has long been at the forefront of polio transition efforts. Even prior to the region being certified as polio-free in 2014, GoI began working with polio partners to transition public health assets and capabilities developed for polio eradication – including immunization and communication strategies, human resources, laboratory capacity, disease surveillance and accountability mechanisms – to government

[7] WHO India NPSP Transition Planning Framework 2018–2021 & 2022–2026

programs. This effort towards polio transitioning is critical to ensuring that activities needed to sustain polio eradication, including surveillance and immunization, are incorporated into all health systems and contribute to broader health goals.

In February 2016, the MoHFW established the Core Group for Polio Legacy Transition Planning for WHO NPSP which has come out with a NPSP Transition Planning Framework (2018-2021 & 2022-2026). Under polio transition, NPSP is expected to continue to devote its time and efforts towards keeping India polio-free, strengthening RI, and accelerating progress towards vaccine-preventable disease elimination goals. In addition, NPSP will support strengthening urban health programmes, particularly those addressing immunization coverage and equity issues. Till date, GoI has released ~$8 million for transition support for WHO-NPSP since FY 2017-18 and ~13.13 million for on-going funding support to labs since 2013-14.

**SMNet**

As part of the polio legacy, the SMNet focused on boosting routine immunization via working with the government to strengthen communication planning, capacity development, social mobilization, media sensitization, monitoring, supportive supervision and evidence-based, real-time planning for routine immunization activities.

SMNet has also played a critical role in MR campaign in 18 states with commendations from State government in overcoming major bottlenecks. This facilitated sharing of lessons and expertise of SMNet in planning and implementation of integrated demand generation activities for MR campaign. Involvement of Influencers, particularly religious and community leaders is becoming the norm of the routine immunization programme.SMNet network has helped to conduct 123,938 number of mother meetings and 1,516,163 number of IPC sessions on RI till September 2019 in Bihar and Uttar Pradesh to raise awareness about the benefits of, and address concerns, myths and misconceptions related to RI. Mosques and other faith-based institutions have been mobilized to regularly make announcements for polio and for routine immunization sessions. 14,787 Public Announcement systems were utilized to announce RI messages in the communities. Immunization IPC training was conducted for ANM – 26,317, ASHA – 55,522, and AWW – 38,635.

Under Gavi HSS2, funds were allocated to support SMNet for 5 quarters. With the government ownership, nearly 60-70% funds are being allocated through government funding, therefore leading to availability of funds for SMNet beyond 5 quarters. State government has rationalised and redeployed SMNet to optimally use the strength of SMNet in supporting immunization program beyond 31st March 2020.

**Electronic Vaccine Intelligence Network (eVIN)**

The 12 eVIN states which were funded through HSS 1 grant have projected eVIN in their state NHM PIPs, to ensure sustainability. Under HSS phase 2, UNDP aims to implement eVIN in the remaining 24 States/UTs in India by 2020. The BOT (Build-Operate-Transfer) approach has been followed and implementation processes have been updated based on lessons learned from HSS phase 1 to aid in a smooth transition of the project into government management and ensure sustainability. These include the following:

State Engagement:

- Pre roll out, a meeting is conducted with the State National Health Mission (NHM) and the State Health & Family Welfare (SHFW) department and to orient the state on eVIN roll out and required human resource.
- In this meeting the states are also encouraged to enter into a Memorandum of Agreement with UNDP to formalize decisions regarding eVIN implementation and transition planning.
- The number of human resources, their designated districts and their remuneration is decided as per state norms.
    - States with large Municipal Corporations or districts with larger number of cold chain points like Tamil Nadu have opted for additional VCCM for these areas.
    - States like Sikkim who have fewer CCP/district have given 1 VCCM the charge of multiple districts.
    - Sikkim being a smaller state has opted to forgo the option of divisional staff.

  - States like Punjab and Tamil Nadu have opted to delegate their internal staff for some posts. Tamil Nadu has delegated their internal staff for State and divisional level. Punjab has delegated their internal staff for district positions
- All vacancies for the project staffs are advertised (in newspapers and web portals) after consultation and agreement with the State.
- The interview panel for recruitment of these resources consists of representatives from State Immunization Cell, State NHM and UNDP in all states and are scheduled as per state representative's availability. All recruitments are supported by an interview report which is formalized by the state.
- All decisions made by the state in regards to eVIN implementation are documented and approved by the state.

Baseline data collection:

- The baseline data collection is conducted by eVIN project staff and not by an external agency. This does result in an increased timeline, but ensures that the project staff knows their districts and vaccine storage points thoroughly and have an in-depth understanding of the vaccine supply and cold chain in their domain. The data is cleaned and re-checked, followed by sharing with the district and state government officials for validation and then is it uploaded on the software.
- An exception has been made in Kerala and Tamil Nadu because there were delays in approvals from the state, resulting in a delayed implementation timeline. Here data is being collected by an external agency with monitoring and supervision by eVIN project staff

Trainings:

- The eVIN training calendar of State, Regional and District Vaccine Store Managers and for sub district Cold Chain Handlers are finalized after consultation with the States.
- All Trainings have State immunization cell representatives in the Trainings.
- The states are also encouraged to include SHFW, State NHM staff and other state trainers who can be trained as Master Trainers of eVIN.

### 5.6 Technical Assistance (TA) (progress on on-going TCA plan)

***Table 6: Progress under PEF TCA 2019***

| Programmatic Area | Activity | Partner | Status as of 30 November 2019 |
|---|---|---|---|
| Programme Implementation/Coverage & Equity | Strengthen immunization in 4 urban cities identified under Intensified Mission Indradhanush (IMI) but not included in HSS-2 proposal. This activity initiated with support from PEF TCA 2018 needs to be continued in 2019 | WHO | Completed |
| Programme Management - LMC | Deployment of one technical officer and one technical assistant to support immunization strengthening activities. These HR were supported by PEF TCA 2018 and need to be continued in 2019 | WHO | On Track |
| Programme Implementation/Coverage & Equity | Strengthen RI microplanning in the state of Arunachal Pradesh through deployment of Rapid Response Team (RRT) members using lessons learnt from the MR campaign. Deployment is needed considering limited capacity at the state level to undertake this activity | WHO | Completed |

| | | | |
|---|---|---|---|
| Health Information Systems (Data) | Strengthen data quality in the state of Karnataka, identify HRAs and low performing districts using data triangulation (surveillance and immunization data, etc.), undertake gap analysis in identified districts and develop district-specific improvement plans | WHO | On Track |
| Health Information Systems (Data) | District workshops for VPD surveillance. Support for state workshop is available through HSS-2, district workshop support is needed to ensure capacity-building of sub-district programme managers and fast-track availability of quality data within three months of state workshop | WHO | Completed |
| Programme Implementation/Coverage & Equity | Support the implementation and monitoring of 'Roadmap for attaining 90% FIC and sustain thereafter' with focus on aspirational districts allocated to UNICEF | UNICEF | Completed |
| Health Information Systems (Data) | Support in upgrading the online Immunization dashboard for data triangulation and decision making at National, State and District level | UNICEF | Completed |
| Programme Implementation/Coverage & Equity | Support planning, cold chain assessment, media orientation and roll out of Pneumococcal and Rotavirus vaccine in identified states and documents the best practices for NVI in India | UNICEF | Completed |
| Vaccine Specific Support | Provide technical support to WHO-India with planning and supporting the post-introduction evaluations, coverage and costing studies in Sikkim State following first year of multi-cohort vaccination with dose 1 and 2 of HPV vaccine. | CDC | Completed |
| Programme Implementation/Coverage & Equity | India has one of the highest disease burden estimates for typhoid fever in the world. Typhoid is becoming an urgent problem with rising antimicrobial resistance severely limiting treatment options. The first typhoid conjugate vaccine (TCV) introduction in world was implemented in India in 2018 in collaboration with the MOHFW, WHO-India, CDC, and other partners. We propose to continue working with WHO-India on the typhoid conjugate vaccine (TCV) project in Navi Mumbai India. We will conduct year 2 activities related to the economic evaluation (year 2 economic evaluation components - health facility costing and cost effectiveness study) to be conducted by the International Vaccine Institute (IVI) in collaboration with WHO-India, WHO-HQ and CDC. In addition, we will provide technical assistance to support the second phase of the TCV campaign in 2019 and multiple evaluation components including coverage, disease surveillance and continuous community | CDC | Re-Programmed |

| | | | |
|---|---|---|---|
| | assessment survey for vaccine effectiveness and impact. The results of this project will be of high value to the NTAGI and at the global levels. | | |

## 6. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

| **Prioritised actions from previous Joint Appraisal** | **Current status** |
|---|---|
| 1. PCV scale-up | Under Gavi support, PCV is available state wide in Bihar, Himachal Pradesh, Madhya Pradesh and in 18 districts of Rajasthan and 19 districts of Uttar Pradesh. Plan is to scale-up state-wide in Rajasthan and Uttar Pradesh in 2020. |
| 2. Rotavirus vaccine scale-up | Under Gavi support, RVV is available in Uttar Pradesh.<br>Under domestic support, RVV is available in rest of the states/UTs of the country. |
| 3. MR scale-up | Under Gavi support, MR campaign is completed in 26 out of 28 Gavi supported states. Under domestic support, MR campaign is completed in 7 states/UTs & is on-going in one state. Further, post MR campaign, MR vaccine has been introduced nation-wide as two dose schedules under Routine Immunization. |
| 4. IPV | Decision letter from Gavi was received for 50% cost sharing by Gavi for 3 years (2019-2021) and till date 6 million doses of IPV have been received. |
| 5. 90% FIC achievement and sustainment | 90% FIC Roadmap is being implemented in the states as per the strategies identified. |
| **Additional significant IRC / HLRP recommendations (if applicable)** | **Current status** |
| N/A | |

## 7. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

| **Key finding / Action 1** | |
|---|---|
| Current response | |
| Agreed country actions | |
| Expected outputs / results | |
| Associated timeline | |
| Required resources / support and TA | |
| **Key finding / Action 2** | |
| Current response | |
| Agreed country actions | |
| Expected outputs / results | |
| Associated timeline | |
| Required resources / | |

| | |
|---|---|
| support and TA | |
| **Key finding / Action 3** | |
| Current response | |
| Agreed country actions | |
| Expected outputs / results | |
| Associated timeline | |
| Required resources / support and TA | |
| **Key finding / Action 4** | |
| Current response | |
| Agreed country actions | |
| Expected outputs / results | |
| Associated timeline | |
| Required resources / support and TA | |
| **Key finding / Action 5** | |
| Current response | |
| Agreed country actions | |
| Expected outputs / results | |
| Associated timeline | |
| Required resources / support and TA | |

Based on the above action plan, please outline any specific technology or innovation demand that can be fulfilled by private sector entities or new innovative entrepreneurs.

| |
|---|
| |

## 8. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

# 9 ANNEXURES:

## *9.1 Compliance with Gavi reporting requirements*

| | Yes | No | Not applicable |
|---|---|---|---|
| **Grant Performance Framework (GPF)** reporting against all due indicators | | | |
| **Financial Reports** | | | |
| Periodic financial reports | | | |
| Annual financial statement | | | |
| Annual financial audit report | | | |
| **End of year stock level report**(which is normally provided by 15 May as part of the vaccine renewal request) | | | capped funding for vaccines |
| **Campaign reports** | | | |
| SupplementaryImmunisation Activity technical report | | | |
| Campaign coverage survey report | | | [8] |
| **Immunisation financing and expenditure information** | | | |
| **Data quality and survey reporting** | | | Not yet released |
| Annual data quality desk review | | | |
| Data improvement plan (DIP) | | | |
| Progress report on data improvement plan implementation | | | |
| In-depth data assessment (conducted in the last five years) | | | |
| Nationally representative coverage survey (conducted in the last five years) | [9] | | |
| **Annual progress update on the Effective Vaccine Management (EVM) improvement plan** | Annexure 9.6 | | |
| **CCEOP: updated CCE inventory** | | | |
| **Post Introduction Evaluation (PIE)** | | | |
| **Measles & Rubella situation analysis and 5 year plan** | | | |
| **Operational plan for the immunisation programme** | | | |
| **HSS end of grant evaluation report** | | | |
| **HPV specific reports** | | | |
| **Reporting by partners on TCA and PEF functions** | | | |

[8] MR Campaign coverage survey not undertaken whereas RCM has been undertaken by WHO#

[9] Coverage Evaluation Survey is under review by MoHFW; will be shared with Gavi once they are finalised.

# *Intensive concurrent monitoring including real-time rapid convenience monitoring (RCM) during campaigns, sero-surveys conducted to assess the reach of the MR campaign in the identified high-risk and underserved populations. Approximately ~404,000 MR vaccination session sites were monitored and ~3.6 million children verified through RCM in the communities. The RCM findings from 32 states that have completed the campaign show about 92% children vaccinated with MR in the areas checked through RCM.*

*The RCM is extremely helpful to identify missed communities, left out pockets and missed children in socially segregated groups, nomadic populations, street children, working children in small enterprises or markets, high risk and hard to reach areas etc. The process specifies visiting 20 target age (9 months to < 15 years) children in 20 households (1 child per household). If a household has more than one eligible child, validate the oldest child in the eligible age group who is physically present at the time of visit. If 1 to 3 children out of 20 monitored is/are found un-vaccinated with MR campaign dose, inform the Medical Officer to motivate and mobilize all missed children to visit nearest outreach or health facility session site for the MR vaccination. If 4 or more children out of 20 are found un-vaccinated with MR campaign dose, then PHC medical officers to repeat the outreach-session site activity and plan for intensified social mobilization in the whole community/urban ward/village in the last week in order to cover the missed children (sweeping repeat activity).*

### *9.2 Mission Indradhanush Coverage Report*

(As on 12 April 2019) [Figures in lakh]

| S. No | Indicator | Ph-1 | Ph-2 | Ph-3 | Ph-4 | IMI | MI-GSA* | MI-EGSA* | Ph-6^ | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | No. of districts | 201 | 352 | 216 | 254 | 190 | 550 | 117 | 75 | 1955 |
| 1 | No. of sessions held | 9.61 | 11.55 | 7.44 | 6.3 | 6.04 | - | - | 0.97 | 41.91 |
| 2 | No. of antigen administered | 190.09 | 172.84 | 151.56 | 118.46 | 158.45 | - | - | 14.52 | 805.96 |
| 3 | No. of pregnant women immunized | 20.95 | 16.83 | 17.83 | 13.18 | 11.86 | 1.13 | 4.29 | 1.13 | 87.20 |
| 4 | No. of pregnant women completely immunized | 11.13 | 8.94 | 9.56 | 7.13 | 6.66 | - | - | 0.62 | 44.04 |
| 5 | No. of children immunized | 75.75 | 70.3 | 62.08 | 46.65 | 59.49 | 5.02 | 15.26 | 4.94 | 339.49 |
| 6 | No. of children fully immunized | 19.81 | 18.17 | 16.34 | 12.25 | 14.01 | - | - | 1.21 | 81.79 |
| 7 | No. of children vaccinated for the first time | NA | 9.31 | 12.06 | 6.84 | 8.55 | - | - | 0.62 | 37.38 |
| 8 | No. of Vit A doses administered | 19.85 | 20.53 | 17.98 | 15.13 | 18.46 | - | - | 1.44 | 93.39 |
| 9 | No. of ORS packets distributed | 16.93 | 13.62 | 21.38 | 16.64 | 11.17 | - | - | 1.07 | 80.81 |
| 10 | No. of zinc tablets distributed | 57.03 | 44.85 | 80.7 | 52.1 | 39.18 | - | - | 0.84 | 274.70 |

*Data taken from GSA/EGSA Portal

^ Data is provisional

*9.3 Key achievements under AEFI surveillance*

| Component | Status | | | | | |
|---|---|---|---|---|---|---|
| | 2013-14 | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-2019 |
| **National AEFI system is active with a designated national committee** | Yes | Yes | Yes | Yes | Yes | Yes |
| **Number of reported serious/severe AEFI cases reported during the financial year** | 611 | 843 | 983 | 1666 | 1592 | 3282 |
| **% of serious /severe AEFI cases notified in a timely manner*** | 27% | 24% | 24% | 25% | 26% | 15% |
| **% of serious/severe AEFI cases investigated (PIR/PCIF) received at national level) in a timely manner as per national guideline*** | 31% | 35% | 31% | 14% | 13% | 6% |
| **% of serious /severe AEFI cases classified within time as per national guidelines*** | 3.1% | 12.1% | 1.7% | 6.1% | 2.4% | 3.1% |
| **NRA AEFI Program assessment held** | | | | Yes | | |
| **Spokesperson training on AEFI** | | | 15 states | | 7 states | |

*Source: AEFI secretariat*

*Note: Data as of 30$^{the}$ Sep 2019; Cases are included in a financial year based on date of vaccination.*

**For FY 2016-17, timeliness of cases are investigated and classified calculated as per AEFI operational guidelines 2015.*

*All denominator taken as number of reported AEFI cases with date of vaccination in a financial year; cases with missing date of notification, date of receipt of FIR/PIR/DIR received at national level are excluded from the numerator.*

*9.4 Geographical scope for HSS 2 support*

| Activity | Geographical scope | | Criteria for selection |
|---|---|---|---|
| | **No. of States** | **Names of States** | |
| **Objective 1: To strengthen and maintain robust data systems to improve evidence based decision making.** | | | |
| Routine immunization monitoring | 20 states | Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand & West Bengal | Routine immunization monitoring being undertaken in these states by WHO NPSP |
| VPD surveillance | 15 states | Andhra Pradesh, Assam, Chandigarh, Chhattisgarh, Delhi, Gujarat , Himachal Pradesh, Karnataka, Maharashtra, Odisha, Rajasthan, Tamil Nadu, Telangana, Tripura, West Bengal | Based on VPD risk prioritization & availability of lab support |
| ANMOL | 19 States (Selected districts) | Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Haryana, Jammu & Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tripura, Uttar Pradesh and Uttarakhand | As per current list shared by MoHFW for procurement of ANMOL tablets. |
| **Objective 2: To improve capacity of human resources for service delivery and program management for equitable and efficient immunization services.** | | | |
| Urban RI | 14select cities (10 under HSS-2 & 4 under PEF TCA) | Assam (Guwahati/Kamrup Metropolitan); Bihar (Gaya, Muzaffarpur, Patna); Karnataka (Bangalore Urban, Bangalore Metropolitan);Madhya Pradesh (Bhopal, Indore);Uttar Pradesh (Allahabad, Agra, Ghaziabad, Kanpur Nagar, Lucknow, Varanasi) | Based on low immunization coverage in urban pockets and in consultation with Ministry of Health & Family Welfare |
| Tribal strategy | 7 States | Gujarat, Chhattisgarh, Jharkhand, Maharashtra, Madhya Pradesh, Rajasthan, Odisha | Based on the overall tribal population in the states, districts with large tribal population, immunization coverages, geographical feasibility etc. |
| WHO TOTs — immunization handbook, health worker module and microplanning | 12 states | Bihar, Chhattisgarh, Haryana, Jharkhand, Madhya Pradesh, Rajasthan, Uttar Pradesh & West Bengal + 2 select NE states+ 2 low performing states | In continuation with Gavi-HSS1 states, select NE states and low RI performing states. |
| RISE | 5 states | Himachal Pradesh, Tamil Nadu Madhya Pradesh Maharashtra | One state each from north, east, west, central and south zones; including one high priority state; and |

| Activity | Geographical scope | | Criteria for selection |
|---|---|---|---|
| | No. of States | Names of States | |
| | | Odisha | ensuring a mix of good, medium and poor performing states |
| **Objective 3: To strengthen vaccine logistics and cold chain management through improved data systems, infrastructure strengthening and human resource capacity.** | | | |
| eVIN | Remaining 24 states/UTs | Remaining 24 states/UTs (Maharashtra, Karnataka, Goa, Andhra Pradesh, Tamil Nadu, Telangana, Uttarakhand, Puducherry, Lakshadweep, Dadra Nagar Haveli, Damn & Diu, Andaman & Nicobar, Kerala, Punjab, Haryana, Chandigarh, Delhi, Tripura, Mizoram, Meghalaya, Sikkim, Arunachal Pradesh, West Bengal, Jammu & Kashmir) | To provide real time information of vaccines stocks at the various level of the Routine Immunization Programme as well as have real time information on the temperature at the various levels of storage in the remaining states of the country through an integrated and innovative approach |
| TOTs for CCH and training of CCTs | All states | All states | To ensure that all cold chain handlers are well equipped with updated information and guidelines to ensure vaccine safety and management. Additionally, all Cold chain technicians are provided hands-on training on all types of equipment available under immunization programme (new and old technology). |
| EVM | 23(16 large states+ 7 North Eastern States) | 16 states (UP, MP, Bihar, Rajasthan, Odisha, Jharkhand, Chhattisgarh, Gujarat, WB, AP, Telangana, Karnataka, Maharashtra, TN, Kerala, Assam)<br>7 NE States- Manipur, Meghalaya, Arunachal Pradesh, Mizoram, Nagaland, Tripura, Sikkim | Majority of vaccines are stored in these large states as they are catering to the biggest share of target population. All NE states have hard to reach and remote areas and it is essential to ensure robust cold chain and supply system. |
| **Objective 4:** | | | |
| SMNet | 2 | UP and Bihar | Over 6500 mobilizers in the renowned Social Mobilization Network (SMNet) support GOI in the two traditional polio reservoir states of Uttar Pradesh and Bihar with robust evidence-based communication strategies for Polio and Routine Immunization in Gavi HSS Application Form 92underserved and high risk communities. |

| Activity | Geographical scope | | Criteria for selection |
|---|---|---|---|
| | No. of States | Names of States | |
| Communication plans and linkages to micro-plans through SBCC cells | 11 states[10]<br><br>5 states[11] | Madhya Pradesh, Odisha Assam, West Bengal, Uttar Pradesh, Bihar, Andhra Pradesh Karnataka, Jharkhand, Maharashtra and Gujarat<br><br>Rajasthan, Chhattisgarh, Nagaland, Manipur, Arunachal Pradesh | Previous Gavi states and addition of four more states as Gavi states to enable interventions in specific geographical areas such as tribal, urban, hard to reach and remote characteristics. |
| CSO partnerships | 9 states | Assam (7 districts)<br>Manipur (1 district)<br>Nagaland (1 district)<br>Odisha (4 districts)<br>Bihar (2 districts)<br>Chhattisgarh (2 districts)<br>Gujarat (2 districts)<br>Maharashtra (5 districts)<br>Uttar Pradesh (6 districts) | Since these states and districts have lowest immunization rates, gender and equity gaps in the country and also potential engagement with CSOs with CBOs. |
| BRIDGE Training | All states | All states | Modules developed, phase 1 in IMI districts completed, phase 2 initiated with Aspirational districts. |
| Media Advocacy | (9+2states) | 9-Bihar, Rajasthan, UP, MP, Assam, Chhattisgarh, Jharkhand, Gujarat, Assam<br>2 Additional- Andhra Pradesh and Telangana | After extensive mapping, UNICEF has chosen 9 priority states – Bihar, Rajasthan, UP, MP, Assam, Chhattisgarh, Jharkhand and Gujarat which have the lowest rates of RI in the country. In addition to these 9 priority states Andhra Pradesh and Telangana have been added to reach out to Urdu Media. This indicates a pressing need for sustained interventions and addressing the challenges faced in ensuring universal coverage of immunization which is of paramount importance. These 9 high priority states have also been selected bearing in mind the tribal districts in the area which need to be targeted for concentrated awareness created. Additionally, Assam has been selected particularly Gavi HSS Application Form 93 with a focus on targeting the north east states for immunization communication. |

[10] Currently established
[11] Not established as yet.

**CSO Engagement (AIH & VHAI)**

**AIH States:**

| State | District |
|---|---|
| Andhra Pradesh (3) | Visakhapatnam, Vizianagaram, Kadappa |
| Arunachal Pradesh (1) | Namsai |
| Assam (7) | Dhubri, Goalpara, Barpeta, Hailakandix, Baksa, Darrang, Udalgiri |
| Manipur (1) | Chandel |
| Nagaland (1) | Kiphire |
| Odisha (4) | Koraput, Malkangiri, Khandmal, Bolangir |

**VHAI States:**

| State | District |
|---|---|
| Bihar (2) | Purnea, Gaya |
| Chhattisgarh (2) | Dantewada, Bijapur |
| Gujarat (2) | Dahod, Narmada |
| Haryana (1) | Palwal |
| Maharashtra (5) | Nandurbar, Gadchiroli, Washim, Osmanabad, Malegaon |
| Uttar Pradesh (6) | Sonebhadra, Balrampur, Shrawasti, Siddartnagar, Moradabad, Bareilly |
| Uttarakhand (1) | Haridwar |

*9.5 State wise cumulative coverage of MR campaign*

| State-wise cumulative coverage- MR campaign* | | | | | |
|---|---|---|---|---|---|
| | | (fig. in lakhs) | | | |
| **S.No.** | **States** | **Target** | **Achievement** | **%** | **Remarks** |
| 1 | Karnataka | 160.33 | 158.45 | 98.83 | |
| 2 | Tamil Nadu | 176.05 | 169.53 | 96.30 | |
| 3 | Puducherry | 3.04 | 2.66 | 87.46 | |
| 4 | Goa | 3.20 | 3.12 | 97.30 | |
| 5 | Lakshadweep | 0.16 | 0.12 | 76.25 | |
| 6 | Andhra Pradesh | 118.54 | 114.58 | 96.67 | |
| 7 | Chandigarh | 3.10 | 3.01 | 97.01 | |
| 8 | Daman & Diu | 0.58 | 0.62 | 107.40 | |
| 9 | Dadra & Nagar Haveli | 1.14 | 1.15 | 101.39 | |
| 10 | Himachal Pradesh | 17.74 | 18.08 | 101.88 | |
| 11 | Kerala | 76.55 | 64.88 | 84.76 | |
| 12 | Telangana | 90.01 | 91.48 | 101.63 | |
| 13 | Uttarakhand | 28.36 | 28.76 | 101.43 | |
| 14 | Arunachal Pradesh | 4.38 | 4.43 | 101.06 | |
| 15 | Odisha | 112.26 | 110.37 | 98.32 | |
| 16 | Manipur | 8.18 | 7.94 | 97.03 | |
| 17 | Mizoram | 3.24 | 3.24 | 99.93 | Completed |
| 18 | Assam | 92.09 | 90.28 | 98.04 | |
| 19 | Haryana | 74.38 | 73.67 | 99.04 | |
| 20 | Andaman & Nicobar Islands | 0.83 | 0.78 | 93.53 | |
| 21 | Punjab | 69.64 | 66.84 | 95.98 | |
| 22 | Jammu & Kashmir | 37.62 | 37.57 | 99.87 | |
| 23 | Nagaland | 4.49 | 4.39 | 97.80 | |
| 24 | Gujarat | 151.57 | 145.60 | 96.06 | |
| 25 | Tripura | 9.56 | 8.97 | 93.87 | |
| 26 | Jharkhand | 106.02 | 102.59 | 96.77 | |
| 27 | Chhattisgarh | 77.78 | 77.92 | 100.19 | |
| 28 | Uttar Pradesh | 764.03 | 757.20 | 99.11 | |
| 29 | Madhya Pradesh | 232.45 | 228.22 | 98.18 | |
| 30 | Maharashtra | 290.52 | 278.68 | 95.92 | |
| 31 | Bihar | 377.57 | 384.15 | 101.74 | |
| 32 | Meghalaya | 11.56 | 11.07 | 95.73 | |
| 33 | Sikkim | 1.52 | 1.49 | 98.12 | |
| 34 | Rajasthan | 226.62 | 191.08 | 84.32 | On-going |
| | **Total** | **3335.10** | **3242.93** | **97.24** | |

*Data as on November 2019

### *9.6: Update on EVM Improvement Plan*

| EVM Criteria | Major IP Recommendations | Action taken |
|---|---|---|
| E1-Pre-shipment and arrival procedures | Communication of standard VAR format to all states with SOPs | MoHFW has communicated the VAR formats with SOPs to all states<br>NCCVMRC is following up with states to ensure complete documentation of all VARs |
| | Supportive supervision of VAR entry with feedback | MoHFW has developed new formats for supportive supervision of primary vaccine stores<br>NCCMVRC has developed the data entry modules for the formats and training to states on supportive supervision is ongoing |
| E2-Vaccine Storage Temperature | Completion of training for all VCCH within March 2020 | NCCMVRC has initiated the process of training needs assessment for the revision of the next edition of the Vaccine & Cold Chain Handlers Module for refresher training of all vaccine and cold chain handlers<br>The module revision is expected in 2020 with subsequent cascade training roll out across the country |
| | Printing of standard temperature log books at all cold chain points | Printing of temperature log books ongoing at state level based on need<br>Provision of funds for printing included in annual NHM PIP |
| | Review of temperature records at all cold chain points | eVIN based review of storage temperatures ongoing at national, state and district level in states with functional eVIN data loggers |
| E3-Storage Capacity | Standard vaccine distribution plan and redistribution of existing deep freezers to ensure adequate freezer space at all cold chain points | Standard vaccine distribution plans have been developed at all cold chain points<br>MoHFW has communicated the need to redistribute existing deep freezers to ensure adequate freezer space to all states<br>NCCMIS is being used and followed up by NCCVMRC to track space deficits at all cold chain points and provide appropriate local solutions |
| | Development of standard vaccine storage emergency plans at all vaccine stores | Standard formats for vaccine storage contingency plans have been developed and communicated to all states by MoHFW<br>Compliance to guidelines are being followed up by the district level vaccine and cold chain managers |
| E4-Buildings, cold chain equipment and transport systems | Follow up on construction/ renovation of primary and sub national vaccine stores | Ongoing activity with need based financial approvals being provided by MoHFW through the annual NHM PIP based on final construction/ renovation plans submitted by state |
| | Follow up of breakdown rates and condemnation of broken-down cold chain equipment | NCCMVRC regularly follows up on the status of the cold chain inventory in the country with quarterly feedback and updates to the MoHFW for guidance to states |
| E5-Maintenance & Repair | Preventive maintenance plans for building, transport and cold chain equipment to be implemented and documented | NCCVMRC has developed the standard guidelines for preventive maintenance of cold chain equipment which has been communicated to all states by the MoHFW.<br>The tracking of preventive maintenance visits and activities is being done by NCCVMRC through NCCMIS regularly with quarterly feedback to MoHFW<br>Standard preventive maintenance plans for buildings and transport are under development and will be communicated to all states in 2020 |
| E6-Stock Management | Scale up of eVIN to cover all states | The eVIN scale up is on target to ensure coverage of all states by 2020<br>Standard vaccine registers formats have been distributed to all states with financial provisions for printing included in the annual NHM PIP |
| | National level monitoring of vaccine transactions at primary stores | MoHFW regularly follows up vaccine transactions for all primary stores through eVIN<br>Quarterly feedback reports on stock management indicators are provided to all states by MoHFW |
| | Refresher training of all vaccine and cold chain handlers | Please refer to actions under the first recommendation for criteria E2 |

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|---|---|---|
| E7- Vaccine Distribution | Standard vaccine distribution plans for all cold chain points | Guidelines for development of standard vaccine distribution plans for all cold chain points have been developed and communicated to all states by MoHFW including mapping of vaccine distribution routes<br>This activity is being ensured and followed up at district level by the vaccine and cold chain managers |
| E8-Vaccine Management Practices | Training of all vaccine and cold chain handlers with evaluation of training impact | NCCVMRC has initiated the planning for revision of the vaccine and cold chain handler's module in 2020<br>Revision of the module will be followed by cascade training of all vaccine and cold chain handlers across the country |
| E9-MIS & Supportive Functions | Use of standard GoI formats for RI supportive supervision in S4i (Supportive Supervision for Immunization) | All required RI monitoring checklists incorporated in the S4i app on mobile and web platforms<br>Training of trainers on use and review of supportive supervision data ongoing with national ToT of a core master trainer group planned in early 2020<br>National comprehensive S4i dashboard development ongoing and expected to be completed in early 2020<br>Regular review of immunization through S4i dashboard planned in 2020 by all national, state and district program managers |

### 9.7 Key activities timeline for 2020

| | Activity description | Agency | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| | **New vaccine introduction** | | | | | |
| | MR campaign | MoHFW | X | X | X | X |
| | PCV scale up | MoHFW | X | X | X | X |
| | Rota Scale up | MoHFW | | | | |
| | | | | | | |
| | **HSS2** | | | | | |
| | **Objective 1. To strengthen and maintain robust data systems to improve evidence based decision making** | | | | | |
| 1.1 | Routine immunization monitoring to improve coverage and address equity issues | WHO | X | x | x | x |
| 1.2 | Expansion of VPD Surveillance | WHO | X | x | x | x |
| 1.3 | Introduction of ANMOL to improve data collection and management – improves availability of real time data, helps create automated due lists for immunization | UNICEF | X | x | x | x |
| 1.4 | Coverage Evaluation Survey | UNICEF | X | | | |
| 1.5 | To establish an effective platform for various stakeholders to work together in the area of research and immunization | UNDP | X | x | x | x |
| | **Objective 2. To improve service delivery through improved capacity of human resources** | | | | | |
| 2.1 | Capacity building of master trainers for microplanning and RI strengthening | WHO | X | x | x | x |
| 2.2 | Developing a framework for implementation of training activity and implementation of RISE package | JSI | X | x | x | x |
| 2.3 | Development of a tribal strategy for immunization programme | UNICEF | X | x | x | x |
| 2.4 | Enhancing routine immunization quality and coverage, and addressing inequities in urban areas | WHO | X | x | x | x |
| | **Objective 3. To strengthen cold chain and Vaccine logistics systems** | | | | | |
| 3.1 | Capacity development of cold chain and vaccine handlers, technicians and vaccine logistics managers | UNICEF | X | x | x | x |
| 3.2 | NCCMIS augmentation and Immunization Supply Chain-Cold Chain data harmonization | UNICEF | X | x | x | x |
| 3.3 | Support Govt. in review and implementation of EVM Improvement Plans | UNICEF | X | x | x | x |
| 3.4 | Strengthening of Institutions, cold chain infrastructure and equipment | UNICEF | X | x | x | x |
| 3.5 | Establish eVIN system infrastructure in the additional new States/UT | UNDP | X | x | x | x |
| | **Objective 4. To improve demand generation for immunization services to improve coverage and address inequities** | | | | | |

| | Activity description | Agency | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|---|---|
| 4.1 | Capacity development of FLWs /providers on SBCC and IPC through training of master trainers | UNICEF | X | x | x | x |
| 4.2 | Communication planning linked with micro planning to reach high-risk/underserved through SBCC cells | UNICEF | X | x | x | x |
| 4.3 | Strengthening community based multi-stakeholder partnerships | UNICEF | X | x | x | x |
| 4.4 | Effective use of Polio Network (SMNet) for routine immunization health systems strengthening | UNICEF | X | x | x | x |
| 4.5 | Communication monitoring and supportive supervision through use of standardized formats, dashboard analysis | UNICEF | X | x | x | x |
| 4.6 | Creating enabling environment for immunization through Policy, Media and Advocacy at the national and state level | UNICEF | X | x | x | x |