Memorandum on the Republic of India
Programme Audit report

The attached Audit and Investigations report sets out the conclusions of the programme audit of Gavi's support to the Republic of India's Ministry of Health and Family Welfare (MoHFW), executed by the Universal Immunisation Programme (UIP), along with other implementing partners.

The audit team reviewed the UIP and implementing partners' management of Gavi support to the routine immunisation programme provided during the period 1 January 2022 to 31 December 2024. The audit scope included the following grants: Health Systems Strengthening and COVID-19 Vaccine Delivery Support funds as well as vaccines under COVAX support.

Funds directly executed by WHO and UNICEF were not subject to our programme audit and were considered out of scope, in accordance with the United Nations single audit principle.

The report's executive summary (pages 3 to 6) summarises the key conclusions, details of which are set out in the body of the report:

1. There is an overall audit rating of **"Needs significant improvement",** which means, "**One or few significant issues noted.** Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met".

2. In total, 14 issues were identified in the following areas: (i) supply chain management systems (eVIN); (ii) electronic immunisation register (UWIN); (iii) mentoring and monitoring (U-mentor); (iv) training and capacity building (RISE); (v) governance, oversight and programme management; and (vi) budgeting and financial management.

3. To address the risks associated with the issues, the audit team raised 19 recommendations, of which 9 were rated as high priority.

4. Key findings were that:

    a. Ownership of Gavi supported systems at the state levels as well integration with existing health systems, oversight and systems support at national level remains critical for long-term sustainability and user acceptance and adoption at the state levels.

    b. There is a need for a comprehensive technical human resource (HR) mapping and review to ensure that systems and states are adequately supported. Also, long-term sustainability is threatened by inadequate financing of operational support, a process that can only be upheld by the MoHFW as the partners do not have adequate leverage or legal process with the states in the federated context of India.

c. Long-term operational cost financing, due to the systemic issues within the domestic health budget transfer / approval processes, remains a significant sustainability challenge and will impact the continuity of the eVIN system after the transition from Gavi support.

d. There was no comprehensive sustainability plan to support the transition all of Gavi supported costs and capacity building activities at national and subnational levels over to the NHM budgets for UWIN. Several access limitations were noted coupled with limited health work force impacted the completeness of data in the system, and comparability with the existing Health Information Management System (HMIS). Enrolment of cold chain points remains incomplete, and private health facilities have not yet been integrated into the system.

e. Design gaps were noted in U-mentor along with significant reliance on third party with limited knowledge of project management and oversight by the Gavi implementing partner resulting in several unresolved system development issues and inadequate integration and transition planning.

f. There are opportunities for improvement in the CSO strategy, activities and approach to ensure that the CSOs complemented - without duplicating - existing health systems and, incorporated a continuous learning approach. Inefficiencies were noted in the capacity building approach, with limited collaboration amongst the implementing CSOs, overlaps in the activities undertaken by the government agencies and by CSOs in some states.

g. The audit identified USD 370,978 in questioned costs (consisting of USD 105,188 inadequately supported, USD 252,883 irregular and USD 12,907 ineligible expenditure) due to weaknesses in controlling the supporting documentation, which the team attributed to ineffective oversight by in-country stakeholders, and to inadequate document retention processes by the implementers.

The findings of the programme audit were discussed with the Ministry of Health and Family Welfare and implementing partners. They accepted the audit findings, acknowledged the weaknesses identified, and committed to implementing a detailed management action plan.

Gavi management is working with its in-country stakeholders, including the partners, to resolve the issue of questioned expenditures identified during this audit.

Geneva, October 2026

PROGRAMME AUDIT REPORT

Republic of India
August 2025

Gavi
The Vaccine Alliance

Table of Contents

1. Executive Summary 3
2. Objectives and Scope 7
3. Background 10
4. Audit Issues 13
Annexes 49

1. Executive Summary

1.1 Overall audit opinion

Audit opinion:

The audit team assessed the Ministry of Health and Family Welfare's management of Gavi support during the period 1 January 2022 to 31 December 2024 as **"Needs significant improvement"**, which means, "One or few significant issues noted. Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met."

Through our audit procedures, we identified high risk issues relating to supply chain and data management systems; and budgeting and financial management.

To address the risks associated with these issues, the audit team raised 19 recommendations, of which 9 (47%) were rated as high risk. These recommendations need to be addressed by implementing remedial measures according to the agreed management actions.

1.2 Summary of key audit issues

Ref	Description	Rating*	Page
4.1	**Supply chain management systems (eVIN)**	🟥	**13**
4.1.1	The transition and long-term sustainability of eVIN's operational costs remains a persistent challenge	🟥	13
4.1.2	The design of eVIN requires further enhancement to optimise operational efficiency	🟨	16
4.1.3	User proficiency needs to be strengthened across all eVIN modules	🟨	18
4.1.4	Data quality issues continue to affect accuracy and completeness of reporting	🟨	19
4.1.5	Enhancements are needed to optimise the temperature monitoring function	🟨	21
4.1.6	NCCMIS continues to face design limitations and is not being fully utilised	🟨	23
4.2	**Electronic Immunisation Register (UWIN)**	🟥	**25**
4.2.1	Challenges related to UWIN system integration, access and sustainability need to be addressed	🟥	25
4.2.2	UWIN system utilisation requires improvement	🟥	28
4.3	**Mentoring and Monitoring (U-Mentor)**	🟥	**30**
4.3.1	There are opportunities to improve the design of the U-Mentor app	🟥	30
4.4	**Training and Capacity Building (RISE)**	🟨	**35**
4.4.1	The implementation of RISE requires strengthening	🟨	35
4.5	**Governance, Oversight and Programme Management**	🟨	**38**
4.5.1	Governance mechanisms should be linked to the MoHFW governance framework	🟨	38
4.5.2	Gavi's strategic partnership support has been under utilised	🟨	41
4.5.3	The CSO strategy, design and implementation experienced significant delays	🟥	43
4.6	**Budgeting and financial management**	🟥	**46**
4.6.1	There were gaps in financial internal controls resulting in questioned expenditure	🟥	46

** The audit ratings attributed to each section of this report, the level of risk assigned to each audit issue and each recommendation, are defined in Annex 2 of this report.*

1.3 Summary of issues

Through our audit procedures, we identified 14 issues (6 high risk and 8 medium risk) relating to the use and management of Gavi support.

Section 3 of this report provides details of the Republic of India's context and specific challenges in delivering its immunisation programme.

The high-risk issues are summarised below. Details of all the issues are explained in Section 4 of this report.

Sustainability of Gavi's investments

Electronic vaccine intelligence network eVIN

MoHFW rolled out the eVIN system in 2015 digitising information and ensuring real time visibility on vaccine stocks and cold chain equipment temperature across the country. The system represented significant Gavi contribution totalling USD 82 million over the period 2015 to 2025, with funds being channelled through United Nations Development Programme (UNDP). The audit team noted that although eVIN operational costs were included in the Program Implementation Plan (PIP) under the National Health Mission (NHM), the operational reality has indicated a significant delay in release of funds of over six months and up to two years in some states. As a result, Gavi continued to supplement the operations of eVIN with a payment of USD 5.1 million in the period 2022 to 2024, to support states that did not make their payments in time and there is no agreed repayment or recovery plan.

Long-term operational cost financing, due to the systemic issues within the domestic health budget transfer / approval processes, remains a significant sustainability challenge and will impact the continuity of the eVIN system after the transition from Gavi support.

Electronic Immunisation Register (UWIN)

Universal Immunisation Network (UWIN) is India's beneficiary-centric digital immunisation registry designed to digitally capture, track, and monitor individual immunisation events and sessions across the country. This system was officially launched in October 2024 with Gavi contribution totalling USD 39 million over the period 2023 to 2025, also channelled through UNDP.

The audit team noted that while national budget support was indicated at the launch of the system, there was no accompanying comprehensive sustainability plan to support the transition all of Gavi supported costs and capacity building activities at national and subnational levels over to the NHM budgets. The audit also noted access limitations due to One Time Password (OTP) authentication challenges and no access for beneficiaries without photo identification. Also, in our review of the user acceptance and utilisation at facility and community levels, we observed that the limited and sometimes aging health worker force was overburdened with work due to the data entry time restrictions coupled with the other mandatory manual records they had to complete. This resulted in delayed or incomplete data entry, missing records which impacted the completeness of data in the system, and comparability with the existing Health Information Management System (HMIS). This is partly due to the delayed integration planning for immunisation data to provide one point of data entry for the HMIS and Reproductive Child Health (RCH) systems.

While UWIN is still in its early stages of adoption, the audit identified several challenges that may hinder its effective utilisation. Enrolment of cold chain points remains incomplete, and private health facilities—which account for approximately 10% of childhood vaccinations, a significant target population given India's birth data—have not yet been integrated into the system.

The challenges noted, coupled with long-term sustainability challenges may impede the Universal Immunisation Programme's (UIP) objective of having one data source for complete immunisation records and impede the effectiveness and sustainability of Gavi's investment in India.

Mentoring and Monitoring (U-Mentor application)

U-Mentor, is being developed, with Gavi support through United Nations Children's Fund (UNICEF) as a unified, government-owned application for monitoring of routine immunisation (RI) that will include supportive supervision, guides for health workers and cold chain handlers and provide on the job guidance and mentoring. The audit team noted some design gaps including lack of multiple access options and absence of automated Global Positioning System (GPS) tracker which required manual intervention. Also, there is significant reliance on third party with limited knowledge of project management and oversight by the Gavi implementing partner. This has resulted in several unresolved system development issues including incomplete data fields, OTP authentication challenges and checklist errors with delayed partner input, lack of security certification before further piloting and inadequate integration and transition planning.

The deficiencies in system design observed by the audit team, as well as inadequate transition planning and plan for operationalisation pose risks to successful implementation and if not resolved will hamper the impact and effectiveness of the digital tool.

Civil Society Organisation (CSO) strategy design and implementation

UIP designed a zero-dose implementation plan to improve immunisation coverage, reduce vaccine hesitancy and increase social accountability. This plan outlined the engagement of CSOs to address challenges in reaching some communities and close the zero-dose gap. The audit noted opportunities for improvement in the CSO strategy, activities and approach to ensure that the CSOs complemented - without duplicating - existing health systems and, incorporated a continuous learning approach. Inefficiencies were noted in the capacity building approach, with limited collaboration amongst the implementing CSOs, overlaps in the activities undertaken by the government agencies and by CSOs in some states. The audit also noted a need for a transition and sustainability plan ensure long-term efficacy of the interventions undertaken by CSOs.

Should the CSO implementation gaps remain unaddressed, the interventions implemented by the CSOs may not address the zero dose challenges in the country, have lack of integration due to the delays in operationalisation of Community of Practice (CoPD) for India, nor have long-term sustainability. This will also impede Gavi's ability to learn from the implementation of CSO strategy.

Budgeting and financial management

Between 2022 and 2024, Gavi directly disbursed cash grants totalling USD 74.5 million for various initiatives, including Health Systems Strengthening and Covid-19 delivery support (CDS). Gavi disbursed USD 15.5 million to UNICEF, out of which USD 7.1 million was sub-contracted either to civil society organisation (CSOs) or Government Agencies (GA) of which USD 4.3 million relates to HSS and USD 2.8 million relates to CDS.

The audit team questioned USD 370K, 13% of sample selected (USD 80K HSS and USD 290K CDS grants respectively). This was due to weaknesses in controlling the supporting documentation, which the team attributed to ineffective oversight by UNICEF, and to inadequate document retention processes by the implementers.

Until these gaps are addressed, there will be insufficient accountability over the use of Gavi's funds, which could result in these being misused, potentially affecting the programme's effectiveness or future funding.

Overall comment on the sustainability of Gavi funded systems in India

Gavi's investments in India align with the objectives of India's Zero dose implementation plan which includes digitalisation of service delivery processes and development of data driven action plans. This underpins Gavi's investment of over USD 145 million (since 2015) in e-VIN, CoWIN, UWIN, U-Mentor and RISE for effective oversight and monitoring of the immunisation program to support data driven decision making.

The audit observed that all Gavi-supported systems continue to face persistent challenges with OTP authentication, primarily due to limitations in network connectivity and server capacity. As part of the transition of these systems to the MoHFW, the government should ensure that implementing partners proactively explore secure alternative authentication methods compliant with government policies that do not depend on consistent internet access.

While Gavi supported systems and applications development was approved by the MoHFW, ownership at the state levels as well integration with existing health systems, oversight and systems support at national level remains critical for long-term sustainability and user acceptance and adoption at the state levels. In response to a recommendation from the 2022 Gavi programme audit, a dashboard for RI data analytics was planned to support analysis of data from various sources. This dashboard was envisaged to link to existing data sources like the HMIS, VPD surveillance, with linkages to systems developed through Gavi support like U-WIN, eVIN, NCCMIS and others. The dashboard was initially planned for roll out in February 2025 but has been delayed due to a lengthy procurement process which has still not been completed. The delay means that at the implementer level, health workers are required to complete several mandatory manual documents to support the HMIS and RCH portals, access to consolidated datapoints to support key interventions like follow up and tracking of zero dose children remains fragmented in different systems and consequently, timely consolidation and reporting remains limited. The operationalisation is also challenged by the inadequate technical support at national level. While two personnel were hired in response to the 2022 programme audit report, these remain insufficient to support the scale of operations for all Gavi supported systems and applications. There is a need for a comprehensive technical human resource (HR) mapping and review to ensure that systems and states are adequately supported. Also, long-term sustainability is threatened by inadequate financing of operational support, a process that can only be upheld by the MoHFW as the partners do not have adequate leverage or legal process with the states in the federated context of India.

The success of these systems is not only critical for India but for other countries as well, since the scale and diversity of implementation in India can provide essential learnings for Gavi to support successful implementation elsewhere.

Gavi's country delivery team, in recognition of the challenges highlighted in this report, has encouraged Gavi partners and the UIP team to address the highlighted gaps through an action plan focussed on long-term sustainability before the country transitions from Gavi support.

1.4 Financial consequences of audit's findings

Overall, the audit team reviewed transactions totalling USD 2.8 million of which USD 1.45 million relates to HSS and USD 1.35 million relates to CDS, representing 50% of the overall expenditures reported by the CSOs and GAs, incurred during the three-year audit period (2022-2024). The audit team questioned USD 370K (13%) of which USD 80K relates to HSS and USD 290K relates to CDS, most of which were either irregular or inadequately supported, as shown in the summary below:

Table 1– Summary of expenditures questioned by the audit team, by category in USD:

Category of questioned expenditures	Amount questioned (INR)	Amount questioned (USD)	Details (report reference)
Inadequately supported expenditure	8,584,935	*105,188*	4.3.1
Irregular expenditure	20,639,278	*252,883*	4.3.1
Ineligible expenditure *	1,053,414	*12,907*	4.3.1
Total expenditures questioned	**30,277,627**	***370,978***	

** VAT payments totalling USD 2,480 have been excluded from the table above*

1.5 Cash balances

Table 2 – Gavi funds unspent, held on account at the central level by UNICEF, WHO, UNDP and JSI:

Implementing partner	Balance USD	Date	Source of information
NICEF	*9,406,009*	31 March 2025	Confirmation from UNICEF
WHO	*1,002,112*	31 March 2025	Confirmation from WHO
UNDP	*11,475,432*	30 December 2024	Q4 report from UNDP
TOTAL	***21,883,553***		

2. Objectives and scope

2.1 Audit objectives

In line with the respective Partnership Framework Agreement and with Gavi's policy on transparency and accountability, countries that receive Gavi's support are periodically subject to a programme audit, whose primary objective is to provide reasonable assurance that Gavi's resources and support are managed in a transparent and accountable manner through systems that include appropriate oversight mechanisms and that the support is used according to the programme objectives as outlined in individual country agreements.

As a result, the audit team assessed the various processes and programme management arrangements governing Gavi's support (vaccines and cash grants) for which the respective entities were responsible, so as to assess if: the design and operation of the immunisation and logistics systems are effective and sustainable; the existing grant oversight mechanisms provide continuous and reliable assurance on Gavi's investments; and design and operating effectiveness of the existing financial management processes which support the timely utilisation and accountability of funds. The audit team also reviewed the Government's progress in addressing the 2022 programme audit recommendations.

The team also reviewed the relevance and reliability of the internal control systems, relative to the accuracy and integrity of the books and records, management and operational information; the effectiveness of operations; the physical security of assets and resources; and compliance with national procedures and regulations.

2.2 Audit scope

The audit scope covered the period from 1 January 2022 to 31 December 2024. The total cash, vaccines and ancillary support provided by Gavi to India during this three-year period is presented in table below.

Table 3: Cash, PEF TCA, equipment and vaccines support (2022 to 2024) in USD

Grants	2022	2023	2024	Total
HSS	-	*36,689,784*	*22,254,413*	*58,944,197*
CDS	*11,894,941*	*3,745,250*	-	*15,640,191*
Total cash (a)	*11,894,941*	*40,435,034*	*22,254,413*	*74,584,388*
PEF TCA (b)	*503,597*	-	-	*503,597*
Vaccine support				
COVAX – Covid-19 (c)	*690,000,000*	-	-	*690,000,000*
Total = (a) + (b) + (c)	*702,398,538*	*40,435,034*	*22,254,413*	*765,087,985*

Refer Annex 8 for details of PEF TCA funding to partners

2.3 Audit approach

We adopted a risk-based audit approach informed by our assessment of the risks across the immunisation programme areas supported by Gavi. This included programme management, governance and oversight, supply chain and data management systems, budgeting and financial management. In addition, Gavi's supplemental Covid-19 support (vaccines), and the effectiveness of targeted country assistance (TCA) were reviewed.

The programme audit was conducted in two phases: an initial in-country scoping visit between 3 and 7 February 2025, followed by three weeks fieldwork conducted between 24 March and 11 April 2025.

The audit team visited: two GMSDs; 8 state offices and vaccines stores; 10 district offices and vaccine stores; and 30 health facilities. See Annex 4 for a list of sites visited.

Over the three-year period (2022-2024), Gavi's support to India was disbursed to Gavi alliance partners and expanded partners.

During the audit period, Gavi disbursed overall amounts totalling USD 74.5 million as illustrated in table 4, with no Gavi funds being disbursed directly to the Government. The expenditures relating to cash amounts that were subcontracted back to the Civil Society Organisation (CSOs) and Government agencies (GA) by the UN Partners were considered in scope. Hence, the audit team reviewed the CSO and Government agencies resultant activities at the sub-national levels.

Any Gavi funding that was either directly expensed by either UN organisation or was disbursed to the UN's own partners (other than the Government), resulted in these amounts being excluded from our audit review (i.e. out of scope) due to the United Nations single audit principle[1]. Table 4 below summarises the sources of Gavi funding and resultant recipients, and Table 5 focuses on which recipients were selected, and the resultant expenditures reviewed by the audit team.

Table 4: Gavi's cash disbursements by grant and recipient as of 31 December 2024 (in USD)

Cash grants	Fund Recipient	Total	Amounts sub-contracted CSO/GA	Audit comments:
HSS	JSI	*876,800*		Included in scope
	PWC	*38,280*		Scoped out by the audit team
	UNDP	*34,148,644*		Partially tested as per * below
	UNICEF	*14,587,152*	*4,290,442*	Transfers to CSO / GA included in scope
	WHO	*9,293,321*		Out of Scope
Sub-total HSS		***58,944,197***	***4,290,442***	
CDS	JSI	*990,773*		Included in scope
	UNDP	*10,449,418*		Partially tested as per * below
	UNICEF**	*900,000*	*2,836,637*	Included in scope
	WHO	*3,300,000*		Out of Scope
Sub-total CDS		***15,640,191***	***2,836,637***	
Grand Total		***74,584,388***	***7,127,079***	

**The funds received by UNDP were used mainly to support the design and implementation of the eVIN and UWIN system. While the audit did not review specific expenditure at UNDP per the grant agreement signed between Gavi and UNDP, detailed audit work was done on the SMILE system design, policies and implementation at national and sampled provinces.*
*** The amount sub-contracted is more than the amount received by UNICEF due to opening balance lying with UNICEF as on 1 Jan 2022*

Table 5: Percentage of Gavi-funded expenditures reviewed by the audit team.

Recipients	Agencies	Expenditures reported (in USD)	Expenditures reviewed (in USD)	% reviewed by the team
HSS	*CSO through UNICEF*	*1,365,957*	*483,469*	35%
	GA through UNICEF	*1,507,877*	*964,798*	64%
CDS	*CSO through UNICEF*	*1,596,871*	*383,660*	24%
	GA through UNICEF	*1,217,440*	*983,816*	81%
Total		***5,688,145***	***2,815,743***	50%

Note 1 – USD 1.4 million is the balance with CSO / GA

The team sampled and reviewed expenditures totalling USD 2.8 million, which accounted for 50% of the total spending reported by respective entities for the period January 2022 to December 2024 including an examination of the related activities at sub-national level.

During the course of its engagement, the audit team interacted with a range of stakeholders including: the EPI team; various Gavi alliance partners including WHO and UNICEF; Gavi expanded partners such as UNDP and JSI.

[1] The single audit principle is part of an internal control and audit framework of the United Nations system organisations, which entrusts the right to carry out audits of the accounts and statements of the United Nations Organisations to the United Nations Board of Auditors. Its purpose is to avoid duplication of efforts, by minimising disruption and costs to all parties and avoiding conflicting recommendations which could result from any potential misunderstanding of the nature of the United Nations operations. This principle applies with regard to funds directly expensed by the UN agencies, whose audits are conducted based on a common framework and methodology enabling auditors from one institution to rely on the work of other auditors

2.4 Exchange rate

Most in-country expenditures were incurred in cash using the Indian Rupee (INR). For information purposes and as part of the summary of this report, the equivalent amounts are also reflected in United States Dollars (USD). An overall rate was applied to the summary of expenditures, based on the average bank rate across the audit period. This equates to an exchange rate of INR 81.62 against USD 1.00.

3. Background

3.1 Introduction

India, officially the Republic of India, located in South Asia, is the seventh-largest country in the world by area and the most populous country in the world. In 2021, India has a population of 1.44 billion people.[2] The Republic of India is a federal republic consisting of 28 states and 8 union territories.

India's GDP growth rate was consistently above five percent, until it dropped to four percent in 2019, and then shrunk by 8 percent in 2020 due to the coronavirus pandemic; in the years thereafter, it has consistently remained above 6 percent. According to the International Monetary Fund (IMF), the Indian economy in 2024 was nominally worth USD 3.91 trillion; it is the fifth-largest economy by market exchange rates, and is around USD 10.219 trillion, the third largest by purchasing power parity (PPP).[3] India ranks 130 out of 193 countries and territories on the 2023/24 Human Development Index, tracking the global improvement in human development.[4]

3.2 National health sector

As per article 243W and the twelfth schedule of the Constitution of India, provision of health services is a state responsibility. The states are responsible for implementation and supervision of the various programmes and for provision of relevant infrastructure and curative services. The health service delivery system in the country consists of a mix of public sector units/ institutions (government health centres/hospitals at primary, secondary and tertiary levels, super speciality hospitals established by the centre and state ministries of health), private sector, non-governmental organisations, and the Indian systems of medicine.

At the national level, the MoHFW is the central authority responsible for funding and oversight of various programmes and schemes in areas of family welfare, prevention, and control of major diseases. In 2013, the Government of India launched the National Health Mission (NHM) overarching two sub-missions - the National Urban Health Mission (NUHM) and the National Rural Health Mission (NRHM). NHM encompasses the programs related with RMNCH+A, disease control programs, urban health and quality assurance and aids the states for related infrastructure development and HR assistance. All states are required to submit a programme implementation plan (PIP) in advance of each financial year, along with complete projections of funds required to implement the PIP.

3.3 Immunisation in India

The Universal Immunisation Program (UIP) in India is one of the largest in the world, with an annual birth cohort of 27 million new-borns and with an annual estimated budget of approximately USD 1.2 billion. The MoHFW is responsible for funding majority of the national Immunisation programme (for most states the funding ratio for central government and state government is 60:40, for special category and border states, the funding ratio is 90:10 and for union territories, the central government provides the entire funding), providing technical assistance and policy guidance to the states, and for monitoring and evaluation. The funds to the states for the Immunisation program are administered under the National Health Mission; the Immunisation programme is included in the activities of the Reproductive, maternal, newborn, child, and adolescent health (RMNCH+A).

The Universal Immunisation Programme provides vaccines free of cost to protect against 12 VPDs including Diphtheria, Pertussis, Tetanus, Hepatitis B, Meningitis, Pneumonia, Measles, Rubella, Polio, severe form of Childhood Tuberculosis, Rotavirus diarrhoea and Japanese Encephalitis.

The country was certified polio-free in 2014 and eliminated maternal and neonatal tetanus in 2015. To accelerate full Immunisation coverage and to reach the unreached, the Government of India launched an ambitious programme called "*Mission Indradhanush*" in 2014, this is the largest immunisation programme in

[2] India statistics and figures
[3] International Monetary Fund-India profile
[4] UNDP-India rank in the human development index as global development stalls

the world in terms of the number of beneficiaries, geographical coverage and quantities of vaccine used, with nearly 27 million new-borns targeted for Immunisation annually. It is primarily focused on reaching unvaccinated and partially vaccinated children, as well as pregnant women in regions with low immunisation coverage, including high-risk areas. To date, 12 phases of Mission Indradhanush and Intensified Mission Indradhanush have been successfully completed across the country. During these phases, an impressive 54.6 million children and 13.2 million pregnant women received vaccinations.

3.4 Gavi's relationship with India

Over the years, Gavi has supported the country with over USD 1 billion of new and underutilised vaccine introductions, health systems support for equitable uptake and technical assistance. India is the largest Gavi-eligible country and contributes one-third of Gavi's performance on children immunised and routine coverage. However, given this large birth cohort, Gavi has limited its support to catalytic funding to India. The Gavi Board continues to review any new support on a case-by-case basis and because of this approach, Gavi commitments to India have been considerably lower, in proportion to the country's size, compared to Gavi support for other eligible countries[5]. Gavi and the government of India signed a Partnership Framework Agreement in June 2015 that sets out the terms and conditions that apply to all programmes undertaken by the government and funded by Gavi during the term of the agreement.

For the period under review, the Gavi Board had approved the Gavi strategic partnership with India (2022-2026). This included vaccines and cash support of up to USD 250 million. The strategic partnership was designed to maximise benefits for both India and Gavi by:

a) Targeting 143 district having highest number and proportion of zero dose children
b) maximising health impact by accelerating adoption of new vaccines viz. HPV and TCV; and
c) ensuring that vaccine programmes in India will be sustainable beyond 2026 by supporting the Government to plan for the transition and advocating for increased domestic financing of Immunisation.

47% (USD 117 million) of the strategic funding was allocated towards the introduction of HPV and TCV vaccines and 53% (USD 133 million) allocated to the Health Systems Strengthening (HSS) grant.

There is a multi-stakeholder forum – the Immunisation Action Group (IAG) – which is chaired by the Additional Secretary & Mission Director NHM that regularly meets to review performance of the lead implementers and plans where necessary, to ensure alignment and complementarity of development partners' support as well as engaging the State Health authorities to report progress on indicators and suggest corrective actions where needed.

3.5 Entities involved in the executing and managing Gavi's funds.

The MoHFW is the central authority responsible for funding and oversight of various programmes and schemes in areas of family welfare, prevention, and control of major diseases. The Universal Immunisation Program (UIP) under NHM oversees all immunisation activities in India including management of Gavi activities. Implementation of majority of Gavi activities is through four partners i.e., UNDP, WHO, UNICEF and JSI.

3.6 Progress since 2022 programme audit

Gavi conducted the previous programme audit of Gavi support to India in 2022. The prior India audit report was rated "needs significant improvement" based on the results of testing over various areas in scope including governance and oversight, immunisation and logistics systems, vaccine supply management, budgetary and financial management, immunisation data management, and fixed asset management.

The EPI made some progress in implementing the actions agreed by their management, in response to the 2022 Gavi programme audit. Overall, 27 actions were agreed to be implemented by 31 December 2024. At the time of this audit in April 2025, 13 actions were implemented, as evidenced by the supporting

[5] Report to the Gavi Board Programme and Policy Committee 7-8 October 2015

documentation, and were considered closed. There are 8 actions that are on track to be completed by 31 December 2025. The remaining 6 actions have also been postponed to 31 December 2025, as EPI needs to coordinate its actions with other stakeholders. Refer to Annex 11 for the status of the management actions.

3.7 Good Practices

The audit team noted the following good practices while executing the audit:

1. **Improved access and utilisation of eVIN:** The audit team noted that eVIN was accessed by 1 out of 2 GMSDs, all 8 SVS, all 10 DVS, and all 30 CCPs visited. eVIN was managed by government staff at 7 out of 8 SVS, all 10 DVS and all 30 CCPs, who demonstrated their ability to operate its basic modules. eVIN was used for stock management, utilising colour codes to indicate stock status—such as stock-outs, stock within the minimum-to-maximum range, below minimum, and above maximum levels. The system supported the Early-Expiry-First-Out (EEFO) principle by prioritising early-expiry vaccine issuance and issuing alerts if this protocol is not followed. It also blocks the issuance of expired vaccines. Standard Operating Procedures (SOPs) were developed for stock edits, providing guidance on adjusting stock in scenarios such as inter-program transfers, batch management, returns, initial stock receipt, incorrect entries, and stock mismatches. Offline access is also available for both eVIN and UWIN thus enhancing ease of access.
2. **Progress on implementation of UWIN:** The UWIN system, launched in October 2024, was accessed across all 8 State Health Offices, all 10 District Health Offices, and all 30 CCPs visited. State Health Offices were able to access and view dashboards relevant to their respective states, and 8 out of 10 District Health Offices successfully accessed their district-specific dashboards. At the service delivery points, vaccinators interviewed were able to log into the UWIN system and demonstrate data entry for pre-booked vaccination sessions.
3. **Alignment with GAVI strategy for India:** The design of immunisation and supply chain systems – eVIN, UWIN, RISE and UMETOR aligns with objectives under GAVI's strategy for India with emphasis on strengthening robust data systems for enhanced evidence-based decision making, improved vaccine supply chain efficiency, enhanced monitoring and evaluation processes and improving immunisation service delivery through capacity building of health care personnel.
4. **Compliance with MeitY guidelines on development of systems:** eVIN, UWIN, U-Mentor & RISE platforms follow the Ministry of Electronics and Information Technology (MeitY) guidance on the adoption of open-source technologies. All four systems are developed using open-source frameworks, ensuring cost effectiveness and fostering easier adoption by Government of India (GoI).
5. **Use of government approved checklists and integrated job aids in U-Mentor App:** U-Mentor- GoI approved support supervision application, includes 9 government endorsed checklists tailored to cover RI session sites (fixed and outreach), delivery points, zero-dose child search, cold chain points, planning units and influencer / community feedback. Each checklist used objective, automatically scored questions facilitating real time performance feedback during support supervision visits. The application also includes integrated job aids for each thematic area facilitating mentoring activities.

4. Findings

4.1 Supply chain management systems (eVIN)

4.1.1 The transition and long-term sustainability of eVIN's operational costs remains a persistent challenge

Context and Criteria

The Electronic Vaccine Intelligence Network (eVIN) is a digital platform developed by the Ministry of Health and Family Welfare (MoHFW), with technical support from UNDP, aimed at modernising vaccine logistics and cold chain management across India. It provides real-time visibility into vaccine stock levels and temperature monitoring at over 30,000 cold chain points.
Since its phased rollout in 2015, eVIN has been scaled nationwide and, by the end of 2020, was operational across all 36 states and union territories, covering every public health facility under India's Universal Immunisation Programme (UIP). Between 2015 and 2025, Gavi, through UNDP, has committed over USD 82 million towards the development and implementation of eVIN. To ensure long-term financial sustainability and national ownership, the operational costs of eVIN were intended to be gradually transitioned to State and Union Territory budgets under the National Health Mission (NHM) by December 2023.

A major milestone in this transition was the integration of eVIN's operational expenses into State Programme Implementation Plans (PIPs) under the NHM funding framework. In February 2022, the MoHFW introduced a dedicated budget line— "eVIN operational cost"—within the NHM-PIP and issued official communications and guidance to all states in 2022 and 2023. The budgeting template included provisions for: Human resource costs (e.g., Senior Project Officers, Project Officers, Vaccine Cold Chain Managers); SIM cards and connectivity for temperature loggers; Refresher training sessions; Travel and mobility allowances; and Equipment maintenance and replacements

Although MoHFW encouraged states to take over eVIN's operational costs, UNDP supported the process by signing non-mandatory Memoranda of Agreement (MoAs) with individual states. These served as interim measures to maintain continuity of services, while giving states the flexibility to choose their implementation approaches. The MoAs outlined roles, fund transfer mechanisms (usually involving advance payments), and implementation responsibilities. Most states adopted this arrangement to retain the support of Vaccine Cold Chain Managers (VCCMs) and Programme Managers (PMs) who had been involved in the initial rollout. Under the MoAs, states were required to release funds in advance to UNDP, which then provided the necessary technical and logistical support. The current status of these MoAs is detailed in Annex 5.2

Under the NHM's PIP framework for centrally sponsored schemes, central government funding contributions vary: 60% for most states, 90% for northeastern and special category states, and 100% for union territories.
As part of the transition process, the source codes for eVIN were handed over to the Ministry of Health and Family Welfare in June 2023. Furthermore, UIP engaged two dedicated technical experts to support the ongoing sustainability of the eVIN system, as recommended in Gavi's 2023 programme audit report. These resources are responsible for the continued technical management and oversight of the eVIN platform.

Condition The audit noted the following challenges in the transition process: **Delays in state fund release have resulted in use of Gavi funds –** Although all states have incorporated the "eVIN operational cost" into the NHM PIPs, the release of funds from the central government is often delayed by up to six months. To mitigate the impact of these delays in the disbursement of funds from the state government to UNDP and to ensure the continuity of eVIN, the technical partner, UNDP, has borrowed funds from the Gavi HSS to cover operational costs for eVIN, with the expectation that the outstanding amounts would be reimbursed by the states before the end of each financial year. As of 31 December 2024, 23 states had accumulated significant outstanding payments from these borrowed funds, with some states owing payments dating back to 2022, totalling up to USD 5.1 million. This amount represents 14% of the HSS funds released to UNDP as of December 2024. This arrangement was not pre-approved by Gavi and was not included in the Gavi-UNDP HSS grant for the period 2023 to 2025. See Annex 5.2 for a breakdown of the borrowed funds by state. **Human resource technical capacity challenges, as highlighted in the previous programme audit, persist –** While UIP has engaged two staff members to support eVIN at the national level and provide ongoing assistance and training to the states, they only began their roles in December 2024. By the time of our fieldwork, no training plan had been developed to ensure a gradual and effective handover of responsibilities. **Post audit** – There were no specific provisions in the grant agreement entered into between Gavi and UNDP for utilisation of Gavi HSS 3 grant to fund eVIN operational costs. However, following the audit, Gavi and UNDP agreed to incorporate the following condition under Clause 2 of the grant agreement: *"HSS Programme funds being used to maintain continuity of eVIN services in the states under transition with funding support from National Health Mission, Government of India to be continued through support from HSS Programme funds and subsequently reimbursed back to HSS Programme on receipt of funds from Government"*	Recommendation 1 To ensure the long-term sustainability of eVIN MoHFW/UIP should collaborate with the UN partner and states to: • Strengthen ownership and prioritisation of eVIN at the state level through formal communication from MoHFW, acknowledging eVIN as the vaccine supply chain logistics management platform. The communication should also include clear timelines for the release of funds for eVIN operations. This should be supported by regular updates and follow-ups via the IAG or mechanism deemed appropriate by MoHFW. • Develop a capacity building plan for the systems specialists at UIP, based on a capacity assessment to build the skills and capabilities of UIP staff responsible for the ongoing maintenance and management of eVIN. Recommendation 2 To ensure that a long-term solution for the overdue payments is resolved, MoHFW and Gavi, together with the UN partner should: • Determine a timeline for the collection of all overdue amounts to ensure timely collection and resolve all amounts that cannot be repaid. • The UN partner should maintain an aging schedule for all funds borrowed from Gavi HSS by state and share this with Gavi and MoHFW leadership on a quarterly basis to ensure transparency in this process.
Root Cause • Ownership of the eVIN system has not been fully realised at both the MoHFW and state levels as initially intended. This is due to the following reasons: • Budgeting for operational costs has not translated into actual fulfilment of payments - Although MoHFW mandated that each state include an eVIN budget line in their NHM budgets, additional coordination with state health departments is needed to advocate for the prioritisation of eVIN funding. The mere inclusion of the budget line	Management comments

<table>
<tr><td>

does not guarantee that the funds will be allocated when received. As a result, some states have not prioritised the payment of eVIN operational costs.
MoAs lack legal enforcement - These MoAs, while agreements between UNDP and state officials, do not have a legal framework for enforcement, meaning states are not legally obligated to make payments to UNDP. Furthermore, while MoAs were with 29 states and union territories, 9 of these MoAs have expired, and 7 states have never signed any MoA, at the time of the audit.

Recruitment of eVIN IT specialist within UIP may have been hampered by civil service recruitment policies. Furthermore, there were delays within the UN partner in formalising a capacity assessment upon which a capacity building plan could be developed.

</td><td colspan="2"></td></tr>
<tr><td>Risk / Impact / Implications
There is a significant risk to Gavi's USD 82 million investment in eVIN if states fail to fund its operational costs, potentially leading to the discontinuation to use the system in many states.
Any disruption to eVIN’s operations at the state level could compromise the visibility of vaccines throughout the supply chain, undermining one of the key reasons for the system’s development.
</td><td>Responsibility</td><td>Deadline / Timetable</td></tr>
</table>

4.1.2 The design of eVIN requires further enhancement to optimise operational efficiency

Context and Criteria

The eVIN digital platform, was designed to offer real-time visibility into vaccine stock levels and cold chain temperatures across the country. The system integrates smartphone and web-based applications, automated temperature loggers, and a secure cloud server to digitise vaccine inventory and temperature data at every level—from Government Medical Store Depots (GMSDs) to State and District Vaccine Stores, and down to Community and Primary Health Centres (CHCs/PHCs). eVIN strengthens the capacity of cold chain handlers and programme managers by embedding digital tools into routine immunisation management. Key features include Real-time inventory tracking; Automated temperature monitoring with alerts; Batch and expiry management; Monitoring of vaccine utilisation and wastage; and Reporting dashboards.

eVIN supports India's Zero Dose Implementation Plan, Objective 3, aims "to digitise service delivery processes and develop data-driven action plans," with one of the key interventions being the implementation of "data analytics for Routine Immunisation (RI) review."

The Universal Immunisation Programme (UIP) is a primary user and crucial stakeholder of digital platforms like eVIN and UWIN, providing operational feedback and requirements. The development, governance, and major updates of these systems are centrally managed by the Ministry of Health and Family Welfare, through the Health Informatics Division.

Condition

The audit team identified the following design challenges within the eVIN tool:

Absence of Near-Expiry Alerts – While eVIN was envisioned to provide real-time, end-to-end visibility of vaccine stocks—including tracking those near expiry to facilitate timely redistribution and reduce wastage, the audit team noted that there was no functionality to provide near-expiry alerts similar to the functionality of stock out alerts. The stock balances were only displayed on the dashboard, without triggering necessary notifications or alerts. The audit team noted expiries in seven health facilities and observed that the near expiry alert function was not configured and was non-functional at all facilities.

Inability to Record Physical Stock Counts in eVIN – The current design of the eVIN system does not support the entry or documentation of physical stock count results, limiting the ability of vaccine handlers to reconcile system data with actual inventory during stock verification exercises.

Design flaws in the visibility of GMSD level stock and vaccine stock arrival records must be addressed – We noted that both the State and Ministry of Health (MoH) users currently have access to stock level data at the GMSD in the eVIN system, due to design flaws in the restricted access. In the current design, unrestricted access Also, there is lack of system guidance for the type of documents which can be uploaded in the vaccine arrival module thus impacting system performance as large and unnecessary documents are uploaded by the users, blocking critical system resources.

Disconnect between the data records – Our review of live eVIN reports, accessed through national manager login credentials, revealed discrepancies for the period 1 December 2024 to 31 December 2024. Specifically, the opening balance, transactions, and closing balance for the sampled vaccine (Pentavalent) were all recorded as "0" for every State Vaccine Store and Government Medical Store Depot (GMSD). In contrast, the corresponding state-level eVIN reports contained complete and accurate transaction data for the same period. This inconsistency highlights a disconnect between

Recommendation 3

To address the design challenges identified in eVIN, UIP in coordination with the Health Informatics Division of MoHFW and the technical UN partner should:

- Establish ongoing data quality reviews by implementing regular system assessments. The assessments should systematically address all design flaws identified in this audit and maintain a tracker for both these issues and any operational problems reported by the states, ensuring timely resolution. Data quality review processes should be included in the final eVIN system handover guidelines.
- Consistently verify the accuracy of inventory data by monitoring eVIN entries for discrepancies, investigating any unusual patterns, and ensuring timely correction of any issues identified.
- Designate a responsible owner within MoHFW/UIP to manage data quality assurance processes, with clear reporting lines to the established governance structures at UIP.

<table>
<tr><td>the state and national reporting layers within eVIN, raising concerns about the accuracy and reliability of the inventory records available to national-level decision-makers as errors may be made during the manual consolidation processes.

Inability to download cumulative historical reports – The eVIN system is configured to download reports for a period up to 6 months, meaning that a user will have to generate multiple reports and consolidate the report outside the eVIN system for longer periods.

Lack of audit trail – As noted in the previous audit, the eVIN platform still lacks an integrated audit trail i.e. no systematic record of user activity, data edits, or transaction histories were available within the system. This limitation may hinder the ability to track changes, identify unauthorised alterations, and ensure accountability. The absence of an audit trail also increases the risk of data manipulation, impedes effective troubleshooting and ultimately affecting data integrity.</td><td colspan="2"></td></tr>
<tr><td>Root Cause
During the development and part of the implementation phases of eVIN, Trygen Technologies conducted regular quality reviews of the source code and the system, ensuring consistent testing and evaluations. However, following the transition from development to ongoing operations, these quality review processes through the vendor were discontinued and not institutionalised in the MoHFW. Also, the transition documents prepared by the UN partner did not include information on data quality requirements. As a result, there is now no established mechanism or schedule in place for regular testing or systematic reviews of the system.
While the eVIN system has now been handed over to MoHFW, specific design processes were ongoing and the audit noted limited monitoring of system configuration and inadequate module testing before rolling out the new features and modules.</td><td colspan="2">Management comments</td></tr>
<tr><td>Risk / Impact / Implications
The design flaws noted may:
Increase the risk of vaccine wastage due to expiry, if stock near expiry is not identified and redistributed in time.
Hamper the country’s and Gavi’s goal for equitable distribution and access to vaccines due to excessive or premature requests.
Hinder data driven decision making.</td><td>Responsibility</td><td>Deadline / Timetable</td></tr>
</table>

4.1.3 User proficiency needs to be strengthened across all eVIN modules

Context and Criteria

A skilled and well-trained workforce is essential for establishing a strong and efficient vaccine supply system, which is further enhanced by technology like eVIN. At cold chain facilities, Cold Chain Handlers (CCHs) are pivotal in managing vaccines, logistics, and cold chain operations across the entire supply chain. As part of its MOAs with the states, UNDP has spearheaded capacity-building efforts under eVIN by deploying VCCMs and PMs at the district level. VCCMs offer technical support and training to CCHs, focusing on areas such as temperature monitoring, program planning, and implementation.

Condition

During the audit visits to Government Medical Store Depots (GMSDs) and cold chain points (CCPs) at the sub-national level, the audit team reviewed historical temperature monitoring data generated via eVIN by Vaccine Cold Chain Managers (VCCMs) and noted the following challenges:

Limited refresher training on eVIN usage – During the audit, it was observed that Cold Chain Handlers (CCHs) at several facilities had not received recent training on the eVIN system. Specifically, this gap was noted at the 2 GMSDs, 2 out of 8 State Vaccine Stores (SVS), 2 out of 10 District Vaccine Stores (DVS), and 5 out of 30 Cold Chain Points (CCPs). Notably, in the states of Assam and Rajasthan, the last recorded eVIN training sessions were conducted in 2016. Also, eVIN training materials and job aids were missing in 2/2 GMSDs, 4/8 SVSs, 6/10 DVSs, and 13/30 cold chain points.

As a result, Cold Chain Handlers (CCHs) at 25 of 30 Cold Chain Points (CCPs) were unable to download essential eVIN reports—such as stock transactions, consumption, stock-outs, and temperature monitoring. These reports are vital for tracking stock trends, identifying stock-out patterns, and informing decisions on vaccine forecasting and cold chain equipment management. Report generation remains dependent on VCCMs.

Recommendation 4

To enhance user proficiency in utilising all modules of the eVIN system, including report downloads, the UIP/MoHFW, in collaboration with its technical partner, should:

- Organise refresher trainings across all states to reinforce knowledge and address evolving needs.
- Distribute eVIN training manuals to all vaccine handling points at every level and actively encourage vaccine handlers to refer to them regularly to ensure optimal system usage.
- Integrate refresher training materials into platforms such as ITMIS and U-Mentor, where applicable, to help mitigate challenges arising from staff turnover.

Root Cause

The budget allocation for eVIN trainings allow for only one session per year, which is insufficient to adequately train both end users and technical teams. Also, the UN partner did not include provisions for refresher training in the handover notes.

Management comments

Risk / Impact / Implications

Vaccine handlers' limited ability to download reports from the eVIN system hinders timely decision-making, which contributes to both vaccine stock outs and inadequate responses to temperature excursions - Between January 2022 and February 2025, stock outs were reported at: 1 out of 2 GMSDs; all 8 SVS; 8 out of 10 DVS; and 25 out of 30 CCPs. Also, unaddressed temperature excursions were noted at both GMSDs, 1 out of 8 SVS, 2 out of 10 DVS and all 30 CCPs.

Responsibility

Deadline / Timetable

4.1.4 Data quality issues continue to affect accuracy and completeness of reporting

Context and Criteria

CCHs are supposed to ensure daily updating of eVIN for all vaccine related transactions. VCCMs were tasked with physically verifying stock levels and reconciling them with records in both the eVIN app and stock registers[6]. To fully realise the benefits of eVIN as a stock management platform, it is essential that the data entered is complete, accurate, and reliable for decision-making.

Condition

Unexplained stock variances in eVIN – The audit team conducted vaccine stock reconciliations for the period January 2025 to the date of the audit, using the formula: *opening balance + receipts – issues – adjustments/wastages*. Unexplained variances were identified for at least one of the five sampled vaccines—Pentavalent, Inactivated Polio Vaccine (IPV), Pneumococcal Conjugate Vaccine (PCV), Measles and Rubella (MR), and Bacillus Calmette–Guérin (BCG)—at the following locations:

- 1 GMSD (where data was available) – See Annex 6.1),
- 4 out of 8 SVS – See Annex 6.2
- 6 out of 10 DVS – See Annex 6.3

Unexplained Variances Between Physical Stock Verifications and eVIN Records – During physical stock verifications at selected locations, the audit team identified discrepancies between actual stock counts and eVIN system records. These unexplained variances were observed at:

- 1 out of 2 Government Medical Store Depots (GMSDs) – See Annex 6.4
- 3 out of 8 State Vaccine Stores (SVS), with two SVS showing variances only at the batch level – See Annex 6.5
- 2 out of 10 Divisional Vaccine Stores (DVS) – See Annex 6.6
- 9 out of 30 Cold Chain Points (CCPs) – See Annex 6.7

Variances between eVIN and manual stock records – The audit team observed that all vaccine handling points maintained manual stock registers and/or stock cards alongside the eVIN system. While 7 out of 8 SVS, 8 out of 10 DVS, and 16 out of 30 CCPs reported using eVIN as their primary vaccine management tool, the remaining sites—including both GMSDs visited—relied primarily on manual records. A comparison between eVIN and manual stock records revealed discrepancies at 1 out of 2 GMSDs, 2 out of 8 SVS, 2 out of 10 DVS, and 15 out of 30 CCPs.

Variances between consumption data in eVIN and HMIS data – The audit team compared pentavalent vaccine consumption data recorded in eVIN with the number of vaccinations reported in HMIS for December 2024, January 2025, and February 2025. In 33% of cases (32 out of 98), the number of vaccinations reported in HMIS exceeded the doses recorded as consumed in eVIN, indicating potential data inconsistencies between the two systems. See Annex 7

Recommendation 5

To improve data quality in eVIN, MoHFW/UIP in collaboration with its technical partner and State health departments should:

- Ensure that all stock receipts and issuances are entered in eVIN on real time basis with backdated data entry restricted to a reasonable period to encourage on time recording.
- Ensure that vaccine handling points should conduct investigations for stock discrepancies noted following physical count.
- Design functionality for stock take recording within eVIN
- Distribute the SOP on stock edits in eVIN and ensure its implementation at all the vaccine handling points

[6] Techno-Economic Assessment of Electronic Vaccine Intelligence Network, 2018

Root Cause	Management comments	
The audit team observed that data entry at all Cold Chain Points (CCPs) was completed retrospectively, rather than in real time resulting in omissions and incorrect batch selection during stock issuance. Additionally, there was no evidence of investigation or corrective action when discrepancies in stock or temperature data were identified, indicating gaps in accountability and data validation processes. This was noted at 2 GMSDs, 4 out of 8 SVS, 4 out of 7 DVS, and 14 out of 30 CCPs.		
Risk / Impact / Implications Incomplete or inaccurate vaccine and logistics data in eVIN may impact decision-making, vaccine stock visibility and accountability.	Responsibility	Deadline / Timetable

4.1.5 Enhancements are needed to optimise the temperature monitoring function

Context and Criteria

India experiences extreme temperature with states experiencing -25°C during peak winters to 50°C during May and June. These challenging climatic conditions highlight the critical need for a reliable and real-time cold chain temperature monitoring system to promptly detect temperature fluctuations and enable swift corrective action in the event of any temperature excursions. As part of the eVIN system, temperature loggers are installed on cold chain equipment to monitor and transmit data on internal storage conditions. Each logger contains a temperature sensor that records readings at specific points within cold rooms, freezer rooms, refrigerators, or freezer units. These loggers are the only physical hardware components of the eVIN system located at vaccine handling points.

Regular maintenance of the temperature monitoring system is essential to ensure that sensors can accurately capture temperature data and transmit it—via wired connection to the loggers and wirelessly from the loggers to the base station. Preventive maintenance[7] plays a critical role in minimising equipment failures and extending operational lifespan by proactively addressing potential issues before breakdowns occur. This approach is key to maintaining the uninterrupted functionality of the cold chain monitoring system.

Temperature mapping of cold rooms involves systematically measuring and documenting temperature variations within refrigerated spaces to ensure consistent maintenance of the required temperature range. This process helps identify potential warm spots and cold spots and evaluates the room's performance under varying conditions, such as temperature fluctuations or power outages. WHO strongly recommends conducting temperature monitoring, mapping, and route profiling studies as they form the basis for evidence-based improvements in cold chain quality, including optimal sensor placement.

Condition

CCE not connected to eVIN temperature loggers – During the visits to the vaccine handling points, the audit team observed that some CCE units storing vaccines were not connected to eVIN temperature loggers. Specifically, 24% (10 out of 41) at SVS, 13% (11 out of 86) at DVS, and 30% (19 out of 63) at CCPs were found to be without eVIN logger connectivity. All CCE at GMSDs were connected to eVIN temperature loggers (See Annex 6.8, Annex 6.9, Annex 6.10 and Annex 6.11).

Also, **preventive maintenance plans were not available at** all 2 GMSDs, 6 out of 8 SVS, 6 out of 10 DVS, and 24 out of 30 CCPs. On further review of the preventative and curative maintenance processes, the audit team noted that preventive and curative maintenance records were not available at all 2 GMSDs, 6 out of 8 SVS, 5 out of 10 DVS, and 18 out of 30 CCPs.

Additionally, cold room temperature mapping, which is critical for large sized cold rooms, was not conducted at the state and divisional vaccine stores to ensure that eVIN temperature sensors were placed in the most optimal locations. This was noted at 6 out of 8 SVS and 3 out of 7 DVS.

Recommendation 6

To enhance the temperature monitoring function of eVIN, MoHFW/UIP in collaboration with its technical partner and State Health Departments should:

- Identify deficiencies in temperature logger availability and install loggers on all CCE used for vaccine storage
- Develop and/or update preventive maintenance protocols for CCE to include maintenance of eVIN temperature loggers as CCE accessories and maintain adequate documentation.
- Prepare schedules for conducting periodic temperature mapping for WICRs and WIFRs and conduct regular temperature mapping as per WHO guidelines

[7] Preventive maintenance is the scheduled and systematic maintenance of equipment to prevent failures and ensure their longevity and functionality.

<table>
<tr><td>Root Cause
The following root causes were identified
• Insufficient number of temperature loggers for all the CCE at the respective vaccine handling points.
• There was no clear guidance available for developing preventive maintenance plans or documenting preventive and corrective maintenance activities for eVIN temperature monitoring loggers, either as standalone processes or as part of broader CCE maintenance. Also, there was no documentation for preventive and curative maintenance activities for CCE and temperature loggers.
• The auditors, in discussion with state-level staff, noted a lack of awareness of the WHO guidance which recommends periodic temperature mapping studies on cold rooms every two to three years.</td><td colspan="2">Management comments</td></tr>
<tr><td>Risk / Impact / Implications
• The lack of preventive maintenance poses a risk to the functionality and lifespan of eVIN temperature loggers, with non-functional units observed in 45% (9 out of 20) of loggers at GMSDs, 10% (3 out of 31) at SVS, 4% (3 out of 75) at DVS, and 10% (5 out of 48) at cold chain points (See Annex 6.8, Annex 6.9, Annex 6.10 and Annex 6.11.
• The absence of temperature mapping studies increases the likelihood of incorrect placement of eVIN temperature sensors and may also hamper the timely repair of CCE where temperature excursions within the CCE are not known.</td><td>Responsibility</td><td>Deadline / Timetable</td></tr>
</table>

4.1.6 NCCMIS continues to face design limitations and is not being fully utilised

Context and Criteria

The National Cold Chain Management Information System (NCCMIS) was piloted by the Universal Immunisation Programme (UIP) in 2014 to enable real-time monitoring and management of cold chain equipment across India. With financial support from Gavi's HSS2 grant (2017–2021), NCCMIS was scaled nationally and enhanced with six key modules, including equipment inventory, spare parts, training (iTMIS), EVM improvement plans, dashboarding, and supportive supervision. Implementation and maintenance responsibilities lie with the National Cold Chain and Vaccine Management Resource Centre (NCCVMRC). NCCMIS is designed to track both electrical and non-electrical cold chain equipment across various levels of the country's healthcare system. It records key details such as the equipment's name, capacity, installation date, and operational status. In addition, NCCMIS maintains records of spare parts distributed to specific cold chain locations. To support the monitoring and management of equipment maintenance, the system logs both preventive and corrective maintenance activities along with their respective dates.

Since the last GAVI audit in 2022, NCCVMRC has made progress in addressing audit issues in the areas of web security, weak passwords and lack of regular security assessments through initiatives like —the issuance of a web secure socket layer[8] (SSL) certificate in March 2025 and the completion of a penetration test by AAA Technologies in June 2024 (certificate number – AAATPL/25/1224-25/IA/068) valid for one year.

Condition

Incomplete data in NCCMIS – The audit team reviewed the CCE inventory in NCCMIS and compared it with the physical inventory at the locations visited by the audit team. The audit team noted that 52% (12/23) of CCE at GMSDs, 16% (12/77) of CCE at SVS, 17% (22/131) CCE at DVS & 6% (7/113) of CCE at CCPs were not registered in NCCMIS. Additionally, it was observed that CCE preventive and curative maintenance plans were not monitored in NCCMIS at all 2 GMSDs, 6 out of 8 SVS, 10 out of 10 DVS and 25 out of 30 CCPs (See Annex 6.8, Annex 6.9, Annex 6.10 and Annex 6.11).

Gaps in user adoption – At GMSD Mumbai, staff assigned to use NCCMIS did not use it as they did not understand the functionality of the system.

Non-functional modules and reporting tools – Key system functionalities—including the GMSD issue reporting tool and cold chain equipment (CCE) modules—were non-operational at the time of the audit.

Unvalidated remediation of security findings – Although a security assessment and penetration testing were conducted, and a security certificate was issued, there was no documented evidence or follow-up to confirm that recommended security improvements were implemented as per recommendations.

Furthermore, NCCMIS continues to operate in isolation and is not integrated with eVIN, as we had recommended in the 2022 programme audit.

Recommendation 7

To enhance the utilisation of NCCMIS, the MoHFW/UIP in collaboration with the state health departments should:

- Advocate for utilisation of NCCMIS by expanding the user base including provision of user rights to CCPs
- Conduct a training needs assessment and follow it up with targeted suer training for system users based on areas of weakness identified

Recommendation 8

To optimise NCCMIS design and functionality, the MoHFW/UIP, in collaboration NCCVMRC should:

- Outline a clear roadmap with actionable timelines to implement the integration between NCCMIS and eVIN. This timeline should be agreed in the IAG and followed up in subsequent discussions.
- Establish a mechanism to follow-up after assessments are completed for the systems that all recommendations have been implemented
- Perform a comprehensive system review to identify system bugs and nonfunctional modules and plan to have these resolved

[8] SSL, or Secure Sockets Layer, is a security protocol that encrypts data transmitted between a web server and a browser, ensuring secure communication

Root Cause	Management comments	
The following root causes were identified • Access to the NCCMIS is limited to state and district health offices. The CCPs did not have log in credentials into the system. • The training on the system has not been aligned to the roles assigned for example - staff assigned to NCCMIS as noted in GMSD Mumbai, have not received tailored training and the personnel (pharmacists)may lack the requisite technical skills to manage specific modules e.g. spare parts. • At the time of the audit, there were only two technical resources with the skill set to upgrade the NCCMIS system at NCCVMRC, this may make it difficult to address all national and state issues in a timely manner. A roadmap is needed to prioritise and keep track of unresolved issues. • While there is a plan of MoHFW for the integration of eVIN and NCCMIS, there was no evidence of how this is tracked for timely implementation. This is critical as NCCVMRC is a separate department from UIP within the MoHFW structure and as such have different priorities.		
Risk / Impact / Implications • Inadequate visibility of CCE inventory across vaccine handling points hampers timely detection and response to equipment breakdowns, misallocations, and losses. Audit findings revealed that 8% of CCE at SVS, 11% at DVS, and 7.5% at CCPs were non-functional on the day of the visit. • Data Inaccuracies of CCE inventory reporting due to no utilisation and errors in the system	Responsibility	Deadline / Timetable

4.2 Electronic Immunisation Register (UWIN)

4.2.1 Challenges related to UWIN system integration, access and sustainability need to be addressed

Context and Criteria

Universal Immunisation Network (UWIN), is India's, beneficiary-centric digital immunisation registry designed to digitally capture, track, and monitor individual immunisation events and sessions nationwide and structured to support India's Universal Immunisation Programme annual targets—covering 29 million pregnant women and 27 million newborns. It was officially launched in October 2024 with support from Gavi totalling USD 39 million over the period 2023 to 2025 and developed by UNDP. By February 2025, the platform had registered over 32.9 million beneficiaries. UWIN supports detailed session planning and beneficiary-level coverage monitoring through modules specifically tailored for frontline health workers, including ANMs (Auxiliary Nurse Midwives) and ASHAs (Accredited Social Health Activists). For citizens, UWIN enables self-registration for vaccination via web portal and mobile app, flexible appointment scheduling, and the generation of secure, QR-based digital vaccination certificates, with optional integration of ABHA Health IDs for seamless lifelong health record management. The system provides automated SMS notifications for registration acknowledgements, vaccination events, and timely reminders, and includes an offline mode allowing health workers to enter data without internet, which auto-syncs once connectivity is restored. UWIN also has dashboard and analytical tools to facilitate real-time monitoring, reporting, and its platform extends access by onboarding both private sector (under pilot phase) and government health facilities. UWIN was conceptualised as an integrated digital platform to improve management of immunisation services for pregnant women and children with planned integration with reproductive and child health portal (RCH). Under this design, UWIN would track and capture all vaccination events while RCH would continue to manage broader maternal and antenatal services.

The Finance Minister of India in her budget speech while presenting the interim budget for FY 2024-25 stated, "The new designed U-WIN platform for managing immunisation and intensified efforts of Mission Indradhanush will be rolled out expeditiously throughout the country".

Condition

Need for sustainability planning – While there is high level of commitment in implementation of UWIN from the Government of India, as evident from the budget speech, there was no documented plan outlining how UWIN will be maintained and financed after the conclusion of GAVI support. During the audit discussions with the technical partner and UIP, we noted that there is no plan on how transitioning ownership, recurring costs (such as software maintenance, cloud hosting, and user support), and ongoing capacity building to government staff and governance structures would be managed. Currently, the UWIN system is being fully managed by UNDP with limited oversight from MoHFW.

The audit team also reviewed the State PIPs and noted that only Bihar state had included a modest incentive within their budget, (INR 500/ USD 6) for Auxiliary Nurse Midwives (ANMs) related to use of UWIN. All other 7 states visited utilise the existing ANM incentive expenditure line that was planned for other existing programmes. Incentives are critical for the work done by ANMs who are reliant on this as their regular payment for the work done within at primary health care level. This financial gap may create a barrier to regular data entry, particularly in under-resourced states.

Integration with other systems – As part of the India's zero dose implementation plan, analytical dashboard for routine immunisation is expected to be developed which will integrate the various digital systems to provide MoHFW with real time information on vaccine availability and immunisation and help decision making. However, multiple systems such as the Health Management Information System (HMIS) and reproductive and child health portal (RCH) exist and are in use at MoHFW and state levels. Also, some states have developed their own immunisation data systems. Currently UWIN has not been integrated with any

Recommendation 9

MoHFW in consultation with the technical partner should:

- Hasten the integration platform as a critical success factor
- In the medium term, consider adoption of alternatives to OTP- for example device based biometric authentication with fallback of local pin or pattern for access to the UWIN platform. OTP failures may likely persist due to intermittent network disruptions while disabling OTP entirely increases the risk of security exposures on UWIN.
- In the short term, review the network accessibility challenges, and include a mapping of where such issues exist to formulate solutions for these geographies
- Develop system dashboards to track login attempts, OTP failures, and access anomalies, including resolutions to ensure that this knowledge is captured for future handover to MoHFW.

of the existing portals. As such ANMs had to enter similar data in both platforms which inevitably results in duplication and an increased workload.

UWIN access challenges due to use of OTP – During the period from October 2024 to January 2025, states reported significant disruptions in record updates on UWIN due to widespread OTP authentication failures. In response, the OTP requirement was removed in February 2025 and alternative mechanisms of accessing with standard username/password logins were introduced. While this change improved access, it also introduced new security vulnerabilities by eliminating a layer of two-factor authentication. Furthermore, there is still no system dashboard or reporting mechanism to monitor OTP delivery, validation rates, or failed login attempts, which may inhibit monitoring and troubleshooting of access issues in real time.

Challenges in registration for persons without photo identification – The audit team identified critical inclusion gaps within the UWIN registration process. Both a photo ID and a mobile phone number are required to register and access vaccination services. This poses a substantial barrier for homeless individuals, migrants, and other marginalised groups who lack official identification or mobile access. Although UWIN accepts up to eight types of identification (such as student IDs, Mother and Child Protection cards, and subsidised ration cards), nearly 4.5% of the population—over 60 million people—still lack any form of acceptable ID as of March 2024. As such many eligible individuals remain unregistered due to these documentation challenges, creating a substantial risk of exclusion from immunisation services.

Recommendation 10

MoHFW in consultation with States and technical partner should to:

- Develop a UWIN sustainability and transition plan, clearly detailing future financing, ownership, and institutional responsibilities.
- Request and review a comprehensive quantification of all fixed and recurring operational costs for UWIN operations and maintenance. These should also include costs of required server space for all Gavi supported systems and apps.
- Identify and quantify the technical capacity need at MoHFW in the first instance, to ensure that all Gavi supported systems and apps have adequate management capacity at this level.
- Prioritise early budget inclusion for operational costs in national and state health plans and aligning UWIN with existing national digital health infrastructure to ensure integration and continuity beyond GAVI support.

Root Cause

- As UWIN was officially launched in October 2024, significant time has been spent troubleshooting system challenges and encouraging adoption, after which sustainability planning will be undertaken as a next step.
- There are gaps in the guiding policies to support integration with other systems. While the integration issues are followed up through the MoHFW/UIP and IAG, progress remains slow. This is because all other existing systems developed within the MoHFW have different departmental owners and the overarching mechanism that oversees all such systems is not visible to the IAG and technical partners. The technical partners have limited influence at the higher MoHFW levels. As such, within the context of the country's governance process, UIP remains responsible to drive and manage integration initiatives with other departments within MoHFW. This is hampered by inadequate technical expertise as even with the recruitment of two inhouse technicians, the inhouse technical capacity remains limited to manage both the eVIN and UWIN systems, in addition to other Gavi supported applications that will be transitioned to MoHFW.
- OTP is dependent on reliable network coupled with adequate server space to manage all requests. These two critical components remain a challenge.
- The inclusion gap noted is a result of the initial system design. This gap was not identified during the pilot phases and as such was not addressed.

Management comments

Risk / Impact / Implications	Responsibility	Deadline / Timetable
• The lack of a sustainability blueprint for UWIN creates a high risk that—once GAVI funding ceases—system maintenance, functional enhancements, critical updates, and even daily operations may be interrupted, potentially reversing gains and compromising service continuity. Without a clear sustainability roadmap, there is a significant risk that these critical processes may be disrupted. • Access and inclusion challenges may discourage adoption of the system which will result in incomplete data in UWIN		

4.2.2 UWIN system utilisation requires improvement

Context and Criteria

U-WIN is a digital platform for digitalisation of all vaccination services provided under the UIP to ensure timely administration of life-saving vaccines to pregnant women and children (from birth to 16 years) against 12 vaccine-preventable diseases. The annual target of UIP is around 29 million pregnant women and 26 million infants (0-1 year). The nation-wide roll-out of U-WIN has been completed. Its key features include 'Anytime Access' and 'Anywhere' vaccination services, generation of Ayushman Bharat Health Account (ABHA) and Child ABHA, citizen module, automated SMS alerts, QR-based e-Vaccination Certificate and offline mode for data entry by vaccinators.

Since its launch in October 2024, there has been an increased daily usage of the platform which has further created awareness and ready access of immunisation services among both citizens and frontline workers. An extensive social media communication campaign for promoting awareness about U-WIN is done through the Ministry's social media handles on various social media platforms[9]. The audit examined the extent of UWIN utilisation at sampled health units 5 months after its launch.

Condition

Incomplete data entry in UWIN undermining data reliability – The audit team assessed the reliability of vaccination data in UWIN by comparing the number of pentavalent vaccinations recorded at cold chain points in UWIN with corresponding data in the Health Management Information System (HMIS) for the months of December 2024, January 2025, and February 2025. There was a 21% difference in the number of vaccinations recorded in HMIS compared with UWIN. Differences were also noted between the consumption as per eVIN and immunisation as per UWIN/HMIS. See Annex 7.

Inconsistent enrolment of cold chain points in UWIN – Although UWIN was launched in October 2024, the audit team found that some cold chain points began using the system only in 2025. For example, Nagwa PHC in Rajasthan started using UWIN in February 2025, while Fursungi PHC in Maharashtra adopted it in March 2025, as indicated by system data.

Adoption by private facilities – According to National Sample Survey Office 2017-18, about 55% of hospitalisations and 70% outpatient visits are handled by private facilities with 10% accounting for childhood vaccinations**.** UWIN has not been rolled out to the private facilities and at the time of the audit was being piloted in five private facilities in Assam. Adoption by private facilities is critical to ensure that complete information is captured in UWIN as a sizeable population in urban areas gets vaccinated at private facilities.

Recommendation 11

To improve utilisation of UWIN, MoHFW/UIP in collaboration with the State Health Departments should:

- In the short term, consider lengthening the data entry timeframe by an additional 48 hours to allow data entry after immunisation sessions.
- Hasten the integration platform to allow for one point of data entry to lessen burden on the health worker force.
- Once integration is complete, agree and update the health records requirements for all HMIS, RCH and UWIN platforms.
- Strengthen UWIN monitor system usage through block-wise analytics, identify non-compliant cold chain points, and implement corrective actions, including training, as needed.
- Conduct monthly comparisons and generate reports to align data between UWIN and HMIS, ensuring completeness, consistency and accuracy across systems till the time the MoHFW adopts UWIN as the single immunisation data recording system.

Root Cause

Management comments

[9] https://mohfw.gov.in/?q=pressrelease-138

<table>
<tr><td colspan="2">

- Vaccinators are currently required to maintain manual immunisation registers, update both the RCH and HMIS portals, and enter data into UWIN. These manual and system-based updates remain mandatory, while UWIN is perceived as an additional workload. As a result, data entry into UWIN is often deferred and typically done only during downtime. Furthermore, as highlighted in finding 4.2.1, there is limited incentive for using UWIN.
- UWIN's restricted data entry window—automatically locking the system at 5:00 PM the day following a session—creates challenges, especially in regions with frequent internet disruptions. This narrow timeframe, within the context that requires completion of multiple documents highlighted above, makes timely data entry difficult when real-time connectivity is not feasible.
- The UWIN system usage is not monitored as part of the data review at the subnational levels – block, district and state.
- UWIN and HMIS data is not triangulated to recheck completeness and accuracy of data within both systems. This element will only be eliminated when integration of both platforms is achieved.

</td></tr>
<tr><td>Risk / Impact / Implications
Suboptimal utilisation of UWIN compromises its reliability, limiting its effectiveness as a tool to provide data for informed decision-making.</td><td>Responsibility</td><td>Deadline / Timetable</td></tr>
</table>

4.3 Mentoring and Monitoring (U-Mentor)

4.3.1 There are opportunities to improve the design of the U-Mentor app

Context and Criteria

One of the activities under India's zero dose implementation plan is monitoring and mentorship (m&m) programme which highlights that generating data through field monitoring by supervisors across the country from the immunisation session sites (outreach & fixed), planning units, cold chain points, delivery points, house to house survey, local influencer feedback and Task Forces feedback is critical to identify gaps on routine basis and utilise evidence to guide corrective programmatic actions from field level to national level. The intervention is based on the already existing concurrent monitoring and supportive supervision intervention under Universal Immunisation Program (UIP). To avoid duplication of platform and multiple datasets, a single unified, govt. owned IT based mobile application (U-Mentor app) for all supervisors (Government/partners) with defined SOPs is being developed with an enhanced focus on increasing the sample size of monitoring, touching almost all session sites to make the data more representative and making the supervision more supportive and solution driven for health worker through mentorship component.

Due to multiple platforms and mechanisms followed by the respective states and implementing partners, the MoHFW was unable to have access to the existing data and had to rely on the partners. There was no visibility with the MoHFW for the overall status of support supervision. As the supervision plan was also developed manually by the respective agencies, hence cannot be monitored by MoHFW for compliance. There was no written feedback mechanism. To mitigate these, the MoHFW intended to implement the mentoring and monitoring application.

U-Mentor is a unified, government-endorsed digital app designed to strengthen supportive supervision and on-the-job mentorship for frontline health workers (FLWs), particularly Auxiliary Nurse Midwives (ANMs) and Cold Chain Handlers. It is being developed by IIT Bombay through UNICEF with funding from GAVI amounting to USD 0.79 million.

U-Mentor key features include:

- Government-Approved checklists and data capture: The app incorporates nine approved checklists tailored to session sites (fixed and outreach), delivery points, cold chain monitoring, house-to-house zero-dose searches, planning units, and influencer/community feedback. Structured, mostly objective questions are used for scoring and feedback Integrated Job Aids: Embedded job aids (PDFs, videos, SOPs, and RISE content) for all thematic areas support real-time mentoring. Content is downloadable for offline access
- Technology for field use: U-Mentor works both online and offline, allowing users to download forms, store data offline, and upload it once connectivity is restored.
- Real-Time monitoring dashboard: A centralised web-based dashboard enables multi-level stakeholders (block, district, state, national) to track progress, identify performance trends, and review summarised scoring at multiple aggregation levels.

The implementation approach mandates that every ANM and cold chain point is to be monitored at least quarterly, with at least 10% of session sites reviewed monthly. U-Mentor is intended as the exclusive tool for immunisation monitoring at all levels, superseding parallel systems currently being followed by states some of whom have developed their own systems. ODK by WHO is used by WHO officials including field monitors and external monitors which is also based on government approved checklists but is not used by anyone else apart from WHO.

Programmatic oversight for U-Mentor is provided by the reconstituted M&M Program Steering Committee, chaired by the Additional Commissioner (Immunisation), and including representatives from MoHFW, UNICEF, UNDP, JSI, CHAI, and 5 states (Bihar, Rajasthan, Haryana, Meghalaya and Maharashtra). The Committee is responsible for refining checklists, developing SOPs, improving data management protocols, and fostering coherence among various immunisation partners and digital platforms.

Currently a minimum viable product (MVP)[10] has been developed, and plans are underway to conduct a pilot.

[10] Minimum Viable Product (MVP) refers to a functional version of a system/ application developed that includes all essential features needed by users. An MVP is designed to enable system pilot to occur and gather feedback to guide future enhancements of the system /application.

Condition

The audit team noted the following design challenges:

Dependence on OTP as the sole authentication method – The audit team reviewed the user authentication process for the U-Mentor application and identified a heavy reliance on OTP mechanism for login. No alternative authentication methods—such as static passwords or backup credentials—are currently available, creating a critical point of failure. This dependency has led to multiple reported incidents where OTP delivery issues, whether via SMS or platforms like WhatsApp, resulted in login delays or complete access denial. Similar issues have been observed in other immunisation platforms, such as UWIN, highlighting a recurring vulnerability across the ecosystem. Furthermore, the team noted that existing fallback options still depend on stable internet connectivity, which is often unreliable in remote or underserved areas.

Manual geo-tagging process – The audit team examined the geo-tagging approach used in the U-Mentor platform and found that GPS coordinates must be manually captured for each data submission. This method has led to operational inefficiencies, requiring users to repeatedly attempt GPS acquisition or physically move outdoors to achieve the required accuracy threshold of approximately 50 meters. A notable incident occurred on October 30, 2024, when a field user was unable to submit critical monitoring data due to persistent GPS inaccuracies. To date, there is no evidence that these issues have been resolved, and concerns remain regarding system efficiency and data completeness, particularly for facilities located in areas with limited network coverage.

Third-Party control over backend and administrative access – The audit team observed that all critical administrative privileges—such as checklist configuration and data uploads—are currently managed solely by the development partner, IIT Bombay. Neither UNICEF, the Gavi implementer, nor MoHFW has super-admin access to the system. Additionally, there are no formal agreements or scheduled plans for the structured transfer of source code, technical documentation, or administrative rights to MoHFW. While the project rollout plan prioritises deployment and end-user training, it lacks explicit provisions for ownership transition. The audit team also noted that the Gavi implementer does not maintain backup copies of the source code, which increases the risk of data loss or recovery failure in the event of a major system disruption.

Unresolved system issues – During the audit period from October 29 to November 6, 2024, the team identified at least 13 system-related issues, including GPS accuracy failures, incomplete data fields, auto-calculation errors, and checklist malfunctions. Many of these issues remained unresolved or were only partially addressed. Most were flagged as "awaiting UNICEF input" or temporarily mitigated through interim workarounds. The audit also found that there was no consistent mechanism in place for escalation or systematic tracking of issue resolution, raising concerns about accountability and long-term system reliability.

Need for integration with existing tools – U-Mentor was developed to serve as a centralised platform for all support supervision activities nationwide. Currently, tools like ODK—widely used by external field monitors—are partner-developed and owned, limiting government access to stored data and risking the loss of historical supervision records

Recommendation 12

To ensure oversight over U-Mentor, MoHFW in collaboration with its technical partner should:

- Ensure the IAG maintains ongoing oversight throughout the development of the U-Mentor App. Strengthen the IAG by including an independent IT project management and technical expert, to be appointed by the MoHFW.
- In addition to oversight through the IAG, prioritise the institution of a technical oversight function for development work completed by IIT Bombay to ensure all upgrades/updates are developed according to best practices and adhere to set guidelines.
- Review the responsibilities of the technical personnel at MoHFW/UIP and assign responsibilities for the U-Mentor app to a technical staff who will follow through the final development and roll out, including integration with other Gavi supported systems.
- Upon rollout of U-Mentor, determine the level of integration required or supercede other tools to ensure that data is maintained in one platform as envisioned.
- Establish a formal roadmap and timeline for the systematic transfer of all critical administrative rights, system documentation, and source code from the development partner (IIT Bombay) to MoHFW.
- Engage in capacity-building to prepare internal teams for ongoing administration, this should be through a structured capacity building plan that includes assessments of degree of skills transfer.

Recommendation 13

This recommendation is written to be more detailed given the technical and project management challenges noted during the audit and at the request of the Gavi implementing partner but does not preclude the partner from understanding and preparing the required checklist.

once partner support diminishes. This underscores the importance of integrating U-Mentor with existing supervision applications or mandating its nationwide adoption to replace other tools. **Need for greater synergy across digital health initiatives –** The audit team reviewed the interoperability of U-Mentor with other ongoing Gavi-supported digital health initiatives and found limited integration beyond basic administrative unit data sharing with UWIN. Notably, U-Mentor does not interface effectively with platforms such as RISE. For example, it does not use performance evaluation results or low scores to automatically trigger enrolment of health workers into relevant refresher trainings on RISE. This lack of synergy limits the potential for data-driven, adaptive capacity-building and supervision. U-Mentor is also expected to provide job aids, recommend training courses, and assess performance based on mentoring and monitoring activities. Without integration with platforms like RISE and ITMIS, these functionalities risk becoming ineffective, undermining the system's overall impact. **Limited scale-up planning and funding risks –** The program's steering committee currently includes five states selected for the pilot and initial implementation phase. However, no formal plan has been developed to scale the application to the remaining states. While the initial development and rollout are being funded through Gavi support, the absence of dedicated long-term funding poses a significant risk. Without sustained financial backing, the application may not be scaled nationally, undermining its intended role as a unified platform for monitoring and mentorship. **Lack of a comprehensive handover checklist –** The audit team evaluated the project's readiness for transition to MoHFW and its long-term sustainability. It was noted that there is no standardised or detailed handover checklist in place to guide the systematic transfer of system ownership from IIT Bombay. This gap raises concerns about the completeness and consistency of the transition process.	To ensure effective design and use of U-Mentor, MoHFW in collaboration with its technical partner should: • Offer a range of authentication methods beyond OTP, including static passwords, biometric verification, and two-factor authentication options that function independently of consistent internet access. Additionally, establish fallback login mechanisms—such as security questions or secure offline codes—to ensure users can still access their accounts if OTP delivery is unsuccessful. • Work with IIT Bombay to integrate automatic GPS capture within the application, leveraging device capabilities to reduce manual entry. • Maintain secure, regularly updated backup copies of source code and essential data in multiple locations to mitigate data loss risks. • Ensure that a comprehensive security assessment is completed prior to further pilot and/or roll out of the system. • Ensure that all the outstanding 13 issues identified as part of the web testing exercise are resolved and closed off. • Create a detailed handover checklist specifying all necessary deliverables for a smooth transition, including **Technical Documentation** • System architecture documentation • Source code (including repositories and version history) • Database design schema and documentation • API integration documentation (including interfaces with UWIN and any other systems) • Security protocols and standards documentation **Operational and Maintenance Procedures** • Maintenance guide for routine system updates, backups, and recovery procedures • Incident management and troubleshooting guide • Hardware assessment to determine infrastructure required to host system and 5-year buffer given data and user estimates **Testing and Quality Assurance** • Complete documentation of test scenarios, results, and defect logs

	• Historical and current bug/issue tracking reports • User acceptance testing (UAT) results and sign-off documentation **Skills transfer plan** • Agreed-upon timeline and detailed schedule for system transition • Knowledge transfer sessions schedule (e.g., technical walkthroughs, training sessions)
Root Cause The following root causes were identified: • Absence of a technical oversight framework for Gavi-supported systems - The audit team identified a lack of a structured technical oversight framework for Gavi-supported digital systems, resulting in reliance on implementing partners who may not possess adequate IT project management expertise. This gap has contributed to several development challenges, including delayed feedback loops and limited supervision of technical tasks undertaken by IIT Bombay. • There is also limited understanding of IT project management within the implementing partner, with system requirements primarily driven by operational users and immunisation specialists. In the absence of a dedicated technical resource, critical development decisions lacked informed oversight, affecting the quality and timeliness of implementation. • Moreover, while the application is intended to transition to MoHFW, the development phase did not include a formal transition framework. This omission has led to a lack of integration and synergy with other Gavi-supported initiatives and existing support supervision mechanisms. • Although MoHFW has recommended the use of a unified application for supervision and mentorship, the success of this vision depends on the effective development, rollout, and adoption of U-Mentor, along with strategic decisions regarding integration with existing tools.	Management comments
Risk / Impact / Implications • Without integration with other existing supervision tools, U-Mentor may fall short of its objective to become the single source of monitoring and mentorship. Seamless linkage is essential to ensure continuity of data, enable informed decision-making based on historical performance, and support long-term system sustainability. • Data completeness and accuracy challenges may persist which may compromise the reliability of monitoring and supervision outputs. • The absence of a structured and consistent transition process for technical assets, institutional knowledge, and administrative rights may result in unclear ownership and accountability over the U-Mentor platform.	Responsibility / Deadline / Timetable

• Limited technical oversight during development has led to gaps in aligning the platform with user and system requirements. Without dedicated IT project management expertise, there is a risk that the platform may not be developed to meet its intended objectives.		

4.4 Training and Capacity Building (RISE)

4.4.1 The implementation of RISE requires strengthening

Context and Criteria

Rapid Immunisation Skill Enhancement (RISE), a capacity-building initiative using digital platform, has been conceptualised and developed by Government of India with support from John Snow India (JSI) and funding from Gavi totalling USD 7.6 million for the period 2019 to 2025, for enhancing the knowledge and skills of the health workers on routine immunisation. RISE was conceptualised based on needs assessment and a human-centered design approach, including feasibility and willingness of front-line health workers to access and use technology like internet and mobile phone.

RISE Key Features and Structure

RISE is designed to complement traditional face-to-face training methods by providing a user-friendly, self-paced, and modular digital platform accessible via both web and mobile applications. The platform currently offers five immunisation modules from the health worker handbook 2018: (a) Immunisation Schedule and Session Management; (b) Injection Safety and Vaccine Administration; (c) Cold Chain Management; (d) Adverse Events Following Immunisation (AEFI); (e) Effective Communication for Addressing Vaccine Hesitancy.

During learner registration, the platform captures the following information: mobile number, name, supervisor's name, and facility details. Facility names are mapped through integration with the Local Government Directory (LGD) to ensure accuracy and consistency in data capture. Currently, the process of account creation is centralised wherein districts compile and share details of eligible learners with the central team via standardised Excel formats. Account setup (addition and deletion) is then managed centrally (national and state) to maintain data integrity and oversight.

Each module has a pre- and post-assessments, SCORM-compliant interactive content, quizzes, and voice-over narration. To enhance accessibility and inclusivity, all content is available in five major Indian languages. Learners who complete modules receive certificates graded Gold (85–100%), Silver (70–84%), and a Master Certificate for successful completion of all modules.
The RISE platform is structured around three principal user roles:

- Learner – frontline health workers who engage with the course material and assessments
- Facilitator (Supervisor) – responsible for monitoring learner progress and providing feedback
- Administrator – oversees system operations, ticket management, dashboards, and user management

RISE was piloted in 5 districts initially, before being implemented in 33 districts under Phase 1 of its implementation under HSS-2 and then subsequently scaled up to 97 additional districts under Phase 2 of the implementation through CDS funding. Under the current ZIP plan, RISE will be implemented in 236 districts. Since its pilot phase in October 2021, RISE has been implemented in a phased manner. By March 2025, it has reached over 122,000 vaccinators across 256 districts in eight states.
While RISE is poised to facilitate online self-paced trainings on Immunisation, the Ministry of Health and Family Welfare (MoHFW) has separately proposed the Immunisation Training Management Information System (iTMIS) developed by the National Cold Chain& Vaccine Management Resource Centre (NCCVMRC) as the official registry for all classroom-based trainings. iTMIS is intended to capture data on in person training events including attendance, facilitator details and training outcomes. Currently there is no linkage between RISE and ITMIS.

India's zero dose implementation plan includes several interlinked activities namely (i) implementation of RISE supported by JSI as the implementing partners; (ii) institutionalised routine immunisation training in India supported by WHO as the implementing partner; and (iii) monitoring and mentorship program supported by UNICEF as the implementing partner. Institutionalised routine immunisation training includes establishment of immunisation training networks across the country in a hub and spoke model wherein a centre of excellence will be developed at the national level with training institutes at the state level and skill enhancement centres at the designated hubs. This would be supported by an integrated MIS dashboard which will be supported by ITMIS.

Condition	Recommendation 14
The audit team identified the following areas for improvement **Misalignment between RISE Platform and the updated health worker handbook –** The audit team reviewed the training content available on the RISE platform and found that all modules were based on the 2018 version of the Health Worker Handbook. However, the Ministry of Health and Family Welfare (MoHFW) released a revised handbook in 2024, and the RISE platform has not yet incorporated updates reflecting the latest protocols, policies, and guidelines. This misalignment has resulted in outdated training materials that fail to address revised best practices, newly introduced vaccines, and updated cold chain management standards. Consequently, frontline health workers may continue to follow obsolete procedures, potentially compromising the quality of immunisation services and adherence to national standards. **Limited ownership and engagement at subnational levels –** RISE implementation remains largely managed by JSI, with minimal involvement from state and district health authorities. There is no sustainability plan or budget integration at these levels, and learners currently bear the cost of accessing training. This lack of local ownership poses a risk to long-term continuity once donor support ends. **Absence of systematic impact assessment –** Although RISE includes pre- and post-tests, no formal impact evaluation has been conducted. There is no baseline data or analysis linking training to improvements in health worker behaviour, vaccine management, or cold chain practices—making it difficult to justify continued investment. **Training is not informed by supervision data –** Training needs are not aligned with findings from supportive supervision (e.g., U-Mentor, WHO monitoring). This disconnect limits the platform's ability to address actual knowledge and performance gaps among health workers. Also, while supervisors and medical officers had access to the platform, they did not have role-specific guidance or digital SOPs. Current onboarding is limited to in-person sessions, which may not be scalable or sustainable. **Weak sustainability planning and missed synergies –** There is no structured approach to leverage existing initiatives like U-Mentor or WHO's training efforts under the zero-dose strategy. This fragmented approach risks duplication, inefficient resource use, and missed opportunities for long-term sustainability. **Lack of integration with National CPD framework –** RISE certificates are not linked to India's official Continuous Professional Development (CPD) system, reducing their value for career progression and limiting motivation for sustained participation. **Lapsed security assessment –** The last mobile app security review was conducted in 2023. No assessment was done in 2024 despite multiple updates, increasing the risk of cybersecurity vulnerabilities and data breaches.	To ensure effectiveness and sustainability of RISE the MoHFW in collaboration with the partner should: • Establish a formal process for periodic review of the RISE platform, covering training content, platform integration, and cybersecurity. Assign a dedicated technical lead within MoHFW to oversee this process and report outcomes to the IAG. • Strengthen state-level ownership and accountability by decentralising operational responsibilities and incorporating RISE-related costs into state health budgets to ensure sustainability. • Develop a comprehensive monitoring and evaluation framework that includes training needs assessments, baseline evaluations, impact measurement linked to key performance indicators, and tracking of pre- and post-training outcomes, including behavioural change metrics. • Integrate RISE with support supervision platforms such as U-Mentor, ensuring that training needs assessments are informed by supervision data. This will enable training modules to directly address gaps identified during health worker evaluations, promoting targeted and effective capacity building. • Ensure functional integration with ITMIS and institutionalise routine immunisation training within the national health system. • Promote digital learning uptake by aligning RISE with national Continuing Professional Development (CPD) policies and frameworks, enabling formal recognition and career progression for health workers.

<table>
<tr><td colspan="2">No Integration with ITMIS – RISE is not linked with the national ITMIS system, resulting in fragmented training data and missed opportunities for centralised tracking and planning. Integration would enhance visibility, support blended learning, and improve sustainability.</td></tr>
<tr><td>Root Cause

• No established process or budget exists for reviewing and updating RISE platform content to align with revised national guidelines and protocols.
• RISE implementation and operational management remain centralised under JSI, with limited ownership or engagement from state and district health authorities. This centralisation is further challenged by the lack of a defined sustainability and resource integration plan at subnational levels.
• There is no mechanism to link supervision or monitoring data—from platforms such as U-Mentor or WHO assessments—with the training needs assessment process for RISE. As a result, training activities are planned independently of actual performance gaps observed in the field.
• Collaboration between JSI and other partners, such as UNICEF, is unstructured and lacks formal agreements, leading to siloed implementation and missed opportunities for synergy.
• RISE's digital certification system was developed independently of national Continuing Professional Development (CPD) policies and standards, and there is no mandate for integration with CPD regulatory bodies.
• There is no enforced policy or automated trigger for conducting annual security assessments of the RISE platform, nor is there a designated owner responsible for cybersecurity monitoring. This has led to lapses following major updates and ongoing exposure to emerging security threats.
• RISE and ITMIS were developed in isolation, without a coordinated integration roadmap. Key functional requirements—such as real-time training data sharing and video content hosting—were not defined or planned for during project inception.</td><td>Management comments</td></tr>
<tr><td>Risk / Impact / Implications
Without strategic improvements in content alignment, sub-national ownership, sustainability planning, integration with supervision systems, and provision of technical support, the RISE platform's ability to effectively and sustainably build immunisation workforce capacity may be significantly constrained.</td><td>Responsibility</td><td>Deadline / Timetable</td></tr>
</table>

4.5 Governance, Oversight and Programme Management

4.5.1 Governance mechanisms should be linked to the MoHFW governance framework

Context and Criteria

Universal Immunisation Programme (UIP) is a part of the National Reproductive and Child Health Programme under the National Health Mission. UIP is responsible for implementing and monitoring immunisation in the country. India's zero dose implementation

ToR of the Immunisation Action Group provides "IAG would have a close oversight on areas related to programmatic, operational and financial management of the partners who would receive direct funding from Gavi for the implementation of these interventions." Further, it outlines the following objectives of the IAG:

- Ensure comprehensive review of UIP which includes targeting Zero Dose as well as drop-out children with the aim to achieve FIC for every child in the selected districts.
- Ensure better coordination between UIP and other health programs to deliver wider CPHC services with the goal of achieving UHC
- Provide strategic direction, oversight, and policy advice on implementation, monitoring and evaluation of the ZIP.
- Ensure efficiency, timeliness, and financial prudence in the implementation of interventions by the partners funded by Gavi.

ToR for the IAG defined the members which included Mission Director (NHM) and SIOs of the Gavi supported States, HSS-3 partner namely UNICEF, UNDP, WHO, and JSI, and other donor supported partners, NUHM, NCCVMRC, ITSU, CoP-Demand, local CSOs and DIO (on rotation basis), Gavi Secretariat, Geneva, BMGF, USAID, WB.

At the state level, a state steering committee (SSC) has been formed on immunisation as well as a state task force on immunisation (STFI). Similarly, there is a district task force on immunisation (STFI) and block task force on immunisation (BTFI) at the district and block level respectively.

The ToR for the IAG, STFI and DTFI also provides for conducting quarterly meetings.

Condition

Integration and transition of IAG into a national governance mechanism – As noted in the previous audit report, the IAG continues to focus only on the Gavi support, mainly with the technical partners with limited oversight over operations. As such, the current IAG is only mandated to oversee the Gavi support for zero dose implementation and is expected to sunset upon conclusion of Gavi support. However, there is an NHM governance mechanism that oversees all governance issues and immunisation activities in the country. There is no clear linkage between the IAG and the national governance mechanism. Hence, to ensure continued focus on immunisation at national level, it is critical to transition IAG into the existing national governance mechanism involving all the states and the partners, especially given some investments with Gavi support were rolled out pan-India.

Involvement of CSOs and DIOs at IAG meetings – The terms of reference of IAG require that CSOs and DIOs are invited to the IAG meetings on rotation basis. We noted that this was not done for the audit period. Also, while the MoHFW included the CoPD representative as a member of the IAG, this secretariat was not functional and therefore could not attend any meetings.

Recommendation 15

To ensure continued oversight over Gavi-supported programmes and systems beyond Gavi support, the MoHFW should transition and integrate the duties of the IAG within the existing NHM governance framework by:

- Ensuring clear linkages on how issues discussed at IAG, in its current format, are escalated to the NHM.
- Preparing a comprehensive overview of all Gavi-supported programmes for the NHM governance framework.

Recommendation 16

To strengthen the IAG before its integration and transition to NHM, the MoHFW should:

At subnational levels, district level officials were included in the State monthly review meeting but did not participate in the quarterly State Level Task Force on Immunisation (STFI) meetings. **Feedback at state and district levels is not documented for follow up and to inform supportive supervision plans –** Quarterly state level meetings of the STFI and quarterly district level meetings of the District Task Force on Immunisation (DTFI) are conducted and minutes are recorded, however, written feedback are not provided to the districts and blocks respectively This was noted at all the states and districts visited by the audit team.	• Expedite the operationalisation of the CoPD Secretariat to strengthen CSO involvement at the IAG level and ensure strategic alignment with demand generation efforts. • Reinstate quarterly meetings for IAG, Pre-IAG, STFI, and DTFI, with a fixed calendar and designated accountability for follow-up actions to support timely decision-making. • Develop a standardised system for documenting feedback from review and support supervision visits, ensuring insights are captured, shared, and acted upon. • Broaden national-level oversight to include Gavi-supported activities within MoHFW's strategic planning and monitoring frameworks, promoting integration and sustainability. • Create mechanisms to capture ground-level feedback, such as community scorecards or structured CSO reporting, to inform STFI decision-making and improve responsiveness.
Root Cause • **Limited Integration of Governance Structures:** Within India's federated context, and given the relatively smaller scale of Gavi support compared to government contributions, the Immunisation Advisory Group (IAG) was initially designed solely to oversee Gavi grants. It was not integrated into the broader governance mechanisms of MoHFW or the Universal Immunisation Programme (UIP). In light of Gavi's transitional role, MoHFW opted to maintain separate governance frameworks. • **Delayed Establishment of CoPD Secretariat:** The formulation and operationalisation of the Community of Practice for Demand (CoPD) secretariat faced delays, resulting in inadequate CSO representation and engagement at the IAG level. • **Irregular Coordination Meetings:** Scheduled quarterly meetings for key coordination bodies—including IAG, Pre-IAG, State Task Force for Immunisation (STFI), and District Task Force for Immunisation (DTFI)—have not occurred consistently. This has negatively impacted timely decision-making and strategic alignment. • **Lack of Feedback Documentation:** There is no formal system for documenting feedback provided during review and support supervision processes, limiting institutional learning and accountability.	Management comments
Risk / Impact / Implications The absence of integrated oversight at the national level risks creating a narrow focus on Gavi-supported activities, without alignment or integration into broader MoHFW initiatives. This fragmentation may reduce the overall effectiveness and sustainability of immunisation efforts.	Responsibility / Deadline / Timetable

Inadequate feedback mechanisms, combined with inconsistent or absent follow-up processes, hinder the timely identification and resolution of operational challenges. This gap also limits the inclusion of ground-level insights that could inform decision-making at the State Task Force for Immunisation (STFI) level.		

4.5.2 Gavi's strategic partnership support has been under utilised

Context and Criteria

The Gavi Board had approved the Gavi strategic partnership with India (2022-2026). This included vaccines and cash support of up to USD 250 million. The strategic partnership was designed to maximise benefits for both India and Gavi by:

a) Targeting 143 district having highest numbers and proportions of zero dose children
b) maximising health impact by accelerating adoption of new vaccines viz. HPV and TCV; and
c) ensuring that vaccine programmes in India will be sustainable beyond 2026 by supporting the Government to plan for the transition and advocating for increased domestic financing of Immunisation.

USD 117 million (47%) of the strategic funding was allocated towards the introduction of HPV and TCV vaccines and USD 133 million (53%) to Health Systems Strengthening (HSS) grant.

Condition

The rollout of HPV and TCV vaccines has experienced significant delays – At the time of the audit, no official timeline had been established for their introduction. Although discussions were ongoing, challenges in supply planning continued to hinder progress. During the audit debrief, MoHFW indicated that HPV rollout is expected to begin by the end of 2025, with a pilot for TCV planned for early 2026.

De-prioritisation of mobiliser incentive – One of the planned activities under the zero-dose implementation strategy was to provide an incentive of INR 25 per mobiliser to support the uptake of UWIN in Gavi-supported districts. A total of USD 9 million was earmarked for this initiative. However, implementation was stalled due to resistance from states, as the incentive mechanism was not designed for nationwide rollout and was limited to select districts. This raised concerns about unequal compensation across regions, and states were unable to commit additional funds to scale the model nationally.

As a result, only one district in Jharkhand implemented the incentive mechanism. During the Joint Appraisal in November 2024, stakeholders agreed to deprioritise the activity and reallocate the funds to other initiatives. However, discussions on reallocation have not yet been initiated or approved at the IAG level, leaving the funds unutilised.

Recommendation 17

The MoHFW should:

- Develop roadmap for introduction of HPV and TCV and ensure implementation as committed by Government within the 2022-2026 India-Gavi strategic partnership period.
- Reprogram the available funding under the mobiliser incentive, following Gavi's reprogramming guidelines.

Root Cause

The following root causes were identified for the two issues above:

- Vaccine introduction in India requires extensive supply planning due to the large size of its target population compared to other Gavi-supported countries. Additionally, national budget allocations play a more significant role than Gavi support, meaning that planning cannot be finalised until domestic budgets are confirmed. Further complicating the process, state-level approvals are also required to ensure a smooth and continuous rollout. At the time of the audit, several critical issues related to the rollout of HPV and TCV vaccines remained unresolved. While discussions were ongoing, these challenges continued to impede progress and delay the establishment of a clear rollout timeline.

Management comments

• Delays in reprogramming the mobiliser incentive are primarily due to the absence of a clear decision at the national level, compounded by the infrequency of IAG meetings needed to follow up on such issues. This lack of timely coordination has stalled progress and left the reallocation of funds unresolved.		
Risk / Impact / Implications • Under-utilisation of Gavi support of USD 119million for vaccine introduction and USD 9million for incentives • Failure to introduce HPV and TCV in India impedes the realisation of the country's health goals and Gavi's objectives.	Responsibility	Deadline / Timetable

4.5.3 The CSO strategy, design and implementation experienced significant delays

Context and Criteria

Gavi's Civil Society and Community Engagement strategy is built around three core pillars: Advocacy, Demand Generation, and Service Delivery. In alignment with this approach, India developed a Zero-Dose Implementation Plan (ZIP) in 2024 to guide activities under the Gavi grant. The ZIP places a strong emphasis on demand generation and social and behaviour change throughout the strategy period. The plan aims to establish and operationalise a comprehensive and interconnected ecosystem for demand creation and CSO engagement, with a focus on impact, systems strengthening, multisectoral convergence, and sustainability. This ecosystem is designed to be closely aligned with the broader governance and service delivery mechanisms.
India's immunisation coverage for Penta-3 in 2023 stood at 91%, with an estimated 1.6 million zero-dose children. The CSO strategy was adopted to both increase immunisation coverage and reduce the number of zero-dose children.

The engagement of CSOs was designed to achieve the following: (1) Enhance community awareness of vaccination and its benefits; (2) Reduce vaccine hesitancy and (3) Strengthen social accountability for immunisation services.

Gavi support includes the establishment of a Community of Practice for Demand (CoPD) to guide CSO activities and drive demand generation efforts. One of the key goals of the approved strategy is to reduce the number of zero-dose children by 30%, from 1.6 million in 2019 by the end of 2026.

Condition

The audit team reviewed the terms of reference and scope of work of the CSOs and noted the following opportunities to improve the CSO strategy:

Identification vs programming implementation – The audit team's review of CSO activities and funding revealed a heavy concentration of resources on zero-dose (ZD) identification. Of the USD 2.8 million allocated to the five CSOs visited, USD 1.7 million was directed specifically toward ZD identification efforts. However, it remains unclear how the various studies conducted to inform India's ZD strategy and plan were integrated into CSO activity planning. Additionally, while the CoPD team has undertaken research and produced recommendations related to ZD, these insights have not been reflected in the CSO Terms of Reference (ToRs). This has limited the opportunity to recalibrate methodologies, refine activities, and strengthen UNICEF's monitoring and supervision efforts. The audit also noted that CSO ToRs are standardised, with no adaptation to the unique geographic contexts in which each CSO operates.

CSO activities currently lack clear transition and sustainability components in their design – The review of state Programme Implementation Plans (PIPs) revealed that ASHA workers are already incentivised to identify zero-dose (ZD) children. However, there is no clear differentiation in how CSO interventions are designed to complement—rather than duplicate—ASHAs' efforts. This overlap raises concerns about potentially overburdening ASHAs and creating redundancy in service delivery. Moreover, if CSO activities closely mirror existing ASHA processes, the sustainability of ZD initiatives may be at risk once CSO funding concludes, especially if CSOs are perceived as replacing roles that are already embedded within the health system. Additionally, no sustainability plan has been outlined for the continued engagement of community facilitators and influencers, which is essential for ensuring long-term impact.

Recommendation 18

The MoHFW in coordination with the CoPD secretariat and technical partners should:

- Establish the CoPD secretariat meetings, with agreed frequency and oversight over work done by the CSOs and technical partners.
- Review CSO activities and recalibrate the current plan and approach based on agreed recommendations from the CoPD reviews with a focus on implementation, reduced overlaps and sustainability planning
- Update CSO terms of references to reflect changed activities and responsibilities
- Ensure that the CoPD secretariat prepares and presents progress reports on the CSO strategy and implementation in the IAG meetings.

There have been delays in implementing complementary activities that support the CSO approach – The India CSO strategy identified the BeSD survey and social mapping exercises as critical components. However, the BeSD survey was not conducted, and the social mapping process has encountered challenges due to inconsistent methodologies used by different implementing partners. These inconsistencies have delayed progress and undermined the effectiveness of the overall approach. Among the five CSOs visited by the audit team, three had included social mapping in their scope of work. However, neither detailed methodologies nor final social mapping reports were available, further contributing to delays and limiting the strategic value of these exercises.

There is a risk of duplicating capacity building efforts across various activities – The CSO implementation framework includes multiple training initiatives targeting administrative staff, health workers, influencers, and health officers. However, the planning and execution of these activities remain fragmented due to the absence of a comprehensive capacity-building plan. Such a plan should clearly identify all relevant stakeholders, define timelines, and align training efforts with implementation phases. It should also explore potential synergies with other funded initiatives, such as RISE and U-Mentor, to enhance coherence and impact.

Inadequate oversight at block and district levels – Although CSOs are engaging with government structures at the block and district levels, there is no formal reporting mechanism to ensure accountability to the Block Task Force for Immunisation (BTFI) or District Task Force for Immunisation (DTFI). Currently, CSOs submit reports exclusively to UNICEF and participate in BTFI/DTFI meetings, but they do not provide written reports to government officials. This lack of formal reporting limits transparency and weakens local oversight of implementation activities.

Inadequate coordination, collaboration, and knowledge sharing – Collaboration among CSOs operating within the same states remains limited, which restricts the sharing of knowledge and the adoption of best practices. In states such as Rajasthan and Uttar Pradesh, where numerous CSOs and government agencies are active, there is little exchange of information about ongoing initiatives. Furthermore, although WHO has deployed field monitors across all Gavi-supported districts, there is no formal coordination mechanism linking CSOs with these monitors. As a result, monitoring data collected by WHO is not being incorporated into CSO planning processes. Additionally, there is no system in place to track recommendations from monitoring visits or to adjust CSO activities based on those insights.

Duplication between government agencies and CSOs – In several states, both government agencies and CSOs are operating simultaneously, leading to overlaps in their respective scopes of work, as observed by the audit team. This has resulted in a lack of clarity regarding roles and responsibilities, making it difficult to assess which specific districts and interventions are being targeted by government agencies. The challenge is compounded by the fact that all districts have been allocated to CSOs, leaving limited visibility into the distinct contributions of government actors. See Annex 9 for details on the scope of work of government agencies and CSOs.

Root Cause	Management comments	
The India zero-dose implementation plan includes 11 Gavi supported interventions. Several interventions have faced significant delays and some of the activities that had not started for example BeSD, Data analytics, RI review, institutionalised training have had a cascading impact on the implementation of other activities under the CSO intervention. **Delay in CoPD activities resulting in missed opportunities –** The CoPD initiative was conceptualised and co-designed with the MoHFW in 2022. However, significant delays in the approval of the CSO programme by MoHFW meant that UNDP could only initiate activities in late 2023, following the disbursement of Gavi funds. The implementing partner, Group M, was onboarded in September 2024, resulting in actual programme activities commencing only at the end of 2024. These delays impacted the rollout of the CSO Strategy, pilot interventions, and research and evaluation components, which were originally intended to be completed within the first six months. Moreover, CoPD research and studies are being conducted concurrently with implementation, leaving limited opportunity for reflection, learning, and strategic recalibration. **Delays in CSO appointment –** The appointment of CSOs was significantly delayed due to prolonged approval processes at MoHFW, which took up to 18 months and subsequently postponed the disbursement of Gavi funds. These delays were further compounded by slow onboarding of CSOs and the subsequent disbursement and training processes, which took an additional 15 months. As a result, implementation timelines were severely impacted.		
Risk / Impact / Implications • Delay in implementation of activities may result in ineffective implementation and missed opportunities. • Lack of synergy among different Gavi supported activities may result in duplication of activities and lack of value for money	Responsibility	Deadline / Timetable

4.6 Budgeting and financial management

4.6.1 There were gaps in financial internal controls resulting in questioned expenditure

Context and Criteria

Section 16 of Annex 2 to the PFA states that: "The Government's use of GAVI's vaccine and cash support is subject to strict performance monitoring. GAVI seeks to use the Government reports and existing country-level mechanisms to monitor performance. The Government shall monitor and report on the use of vaccines and related supplies and the funds provided by GAVI stating the progress made towards achieving the objectives of the Programmers) during the preceding year by submitting the Annual Progress Report(s). The Government shall also share their internal management reports on the use of funds on a quarterly or periodic basis with GAVI. The Government shall also submit all documents and reports that are required to be submitted as part of the Annual Progress Reports and country applications. For certain cash support, GAVI shall monitor and review annually the progress made in the Country towards the funded objectives of the Programmers) by participating in the annual health sector review through existing country-level mechanisms. The Government shall submit all documents relevant to annual health sector reviews as requested by GAVI.

Section 4.3.2 of the grant agreement between the Gavi Alliance ("Gavi") and United Nations Children's Fund ("UNICEF") states that, "*UNICEF shall maintain accurate accounting records documenting how Grant funds are used and disbursed. UNICEF will remain solely responsible for disbursing Grant funds for budgeted Activities*."

Condition

Questioned expenditures amounting to USD 0.37 million – The audit team reviewed a sample of expenditures at various CSOs and GAs during the 3-year audit period (2022 to 2024). For the 9 CSOs sites visited by the audit team the aggregate expenditures which they reported totalled USD 0.94 million, for which 91% of this amount (USD 0.86 million) was reviewed by the team. For the 15 GAs sites visited by the audit team the aggregate expenditures which they reported totalled USD 2.06 million, for which 95% of this amount (USD 1.95 million) was reviewed by the team. Based on all of these transactions that the team reviewed, expenditures totalling USD 0.37 million were questioned, as summarised in the table below (see Annex 10 for details):

Overall

Table 6: Summary of questioned expenditures

Fund Recipients	Expenditures reported	Expenditures reviewed by the audit team	Inadequately supported (a)	Irregular (b)	Ineligible* (c)	Expenditures questioned = (a+b+c)	Expenditures questioned (USD)
CSO CDS	27,574,931	27,574,931	2,604,241	20,582,867	-	23,187,108	***284,101***
GA CDS	15,241,111	15,106,652	109,200	-	25,000	134,200	***1,644***
CSO HSS	29,103,229	24,898,704	1,525,627	56,411	1,028,414	2,610,452	***31,985***
GA HSS	5,958,000	5,958,000	4,345,867	-	-	4,345,867	***53,248***
Total-INR	**77,877,271**	**73,538,287**	**8,584,935**	**20,639,278**	**1,053,414**	**30,277,627**	***370,978***
Total- USD	**954,192**	**901,027**	**105,188**	**252,883**	**12,907**	**370,978**	

** VAT payments totalling USD 2,480 have been excluded from the table above*

Recommendation 19

While the Gavi funding was received by a Gavi implementing partner, the overall responsibility for overseeing Gavi investments is the MoHFW.

To resolve the gaps noted in the operating effectiveness of the oversight over funds disbursed to CSOs and government agencies, we recommend that the MoHFW ensures that:

- All implementing partners (CSOs and government agencies) prepare detailed reconciliations of funds received from the Gavi implementing partner. These reconciliations should include source of funding and should be annexed to the face forms; and
- The UNICEF conducts a thorough review and reconciliation of all expenditures reported by implementing partners, including supporting documents before expenditure is liquidated.
- The role and involvement of assurance provider is re-evaluated to ensure proper accountability over financial management procedures at CSOs and Government agencies.

Table 6.1: Details of questioned expenditures for CDS

Name	Expenditures reported	Expenditures reviewed by the audit team	Inadequately supported (a)	Irregular (b)	Ineligible * (c)	Expenditures questioned = (a+b+c)	Expenditures questioned (USD)
CSO							
Digital Empowerment Foundation (DEF)	5,243,321	5,243,321	2,065,670	-		2,065,670	*25,310*
Ayaan Welfare Society (AWS)	20,582,867	20,582,867		20,582,867	-	20,582,867	*252,192*
Envisions Institute of Development (EID)	1,748,743	1,748,743	538,571	-		538,571	*6,599*
CSO Total	**27,574,931**	**27,574,931**	**2,604,241**	**20,582,867**	**-**	**23,187,108**	*284,101*
GA							
Aravali	6,469,100	6,305,850	-	-	25,000	25,000	*306*
Dean and Principle SLN Medical College- Koraput	8,772,011	8,800,802	109,200	-	-	109,200	*1,338*
GA Total	**15,241,111**	**15,106,652**	**109,200**	**-**	**25,000**	**134,200**	*1,644*
Total (INR)	**42,816,042**	**42,681,583**	**2,713,441**	**20,582,867**	**25,000**	**23,321,308**	*285,745*
Total (USD)	*524,604*	*522,956*	*33,247*	*252,192*	*306*	*285,745*	

** VAT payments totalling USD 836 have been excluded from the table above*

Table 6.2: Details of questioned expenditures for HSS

Province:	Expenditures reported	Expenditures reviewed by audit team	Inadequately supported (a)	Irregular (b)	Ineligible* (c)	Expenditures questioned = (a+b+c)	Expenditures questioned (USD
CSO							
Voluntary Health Association of India (VHAI) - HSS 3	12,424,792	12,025,279	217,556	-	747,503	965,059	*11,825*
CACR - HSS 3	3,355,810	3,355,810	1,308,071	56,411	46,172	1,410,654	*17,284*
Project Concern Intl. India - HSS 3	13,322,627	9,517,615	-	-	234,739	234,739	*2,876*
CSO Total	**29,103,229**	**24,898,704**	**1,525,627**	**56,411**	**1,028,414**	**2,610,452**	*31,985*
GA							
Registrar IIT Bombay	5,958,000	5,958,000	4,345,867	-	-	4,345,867	*53,248*
GA Total	**5,958,000**	**5,958,000**	**4,345,867**	**-**	**-**	**4,345,867**	*53,248*
Total (INR)	**35,061,229**	**3,0856,704**	**5,871,494**	**56,411**	**1,028,414**	**6,956,319**	*85,233*
Total (USD)	*429,588*	*378,071*	*71,941*	*691*	*12,601*	*85,233*	

** VAT payments totalling USD 1,644 have been excluded from the table above*

<table>
<tr><td colspan="2">Inadequately supported expenditure – Inadequately supported expenditure relates to reported expenditure for which the underlying records provided to support the expenditure were inconsistent (higher or lower) with the reported amounts. For e.g. HR time allocation was not available, Invoice for expenditure not available.

Irregular expenditures – Items where the quality of documentation in support of transactions for procurement of goods and services related to implementing various programme activities was not appropriate. For e.g. procurement procedures provided in the entity’s guidelines were not followed among others.

Ineligible expenditures – These ineligible transactions relate to funds used for activities that were not included in the approved budgets.

Further, although no variance was noted between the reported expenditure and FACE forms, it was difficult to undertake reconciliation between the reported expenditure and FACE forms and required multiple reports to be generated from the system to ensure complete reconciliation. Manual reconciliation was required to be undertaken to ensure completeness.

VAT charged to the Programme (USD 2,480) – The audit team also noted that VAT amounting to USD 2,480 was charged to the programme.</td></tr>
<tr><td>Root Cause
There were no periodic reconciliations of partner FACE forms to reported expenditure. UNICEF also did not reconcile expenditure reported to grant agreements to enable tracking to sources of funding.
Detailed verification procedures not undertaken by the partner before liquidation of expenses.
The audit team noted the following deficiencies in the partner review processes - Ineffective follow-up on micro assessment findings, no review of procurement activities, no evidence of follow-up action by partner on the findings of spot check; In the absence of a HACT micro assessment at the time of disbursement, AWS was rated as high risk, however, no mitigation measures such as use of direct payment (to vendors engaged by CSOs) modality or enhanced assurance activities were put in place as required by partner guidance for CSOs.
Underutilisation of the Assurance Provider (AP) mechanism which has not reviewed for funds channelled to CSOs and Government</td><td>Management comments</td></tr>
<tr><td>Risk / Impact / Implications
Implementing partners receiving Gavi support are unable to account for funds received appropriately and this could result in errors in financial reports submitted to Immunisation Action Group (IAG) thus limiting the decision making of those charged with governance.</td><td>Responsibility</td><td>Deadline / Timetable</td></tr>
</table>

5. Annexes

Annex 1 : Acronyms

ANMOL	Auxiliary Nurse Midwives Online
CCE	Cold Chain Equipment
CoWIN	COVID-19 Vaccine Intelligence Network
DVS	District Vaccine Stores
eVIN	Electronic Vaccine Intelligence Network
GMSD	Government Medical Store Depots
GoI	Government of India
HF	Health Facility
HSS	Health System Strengthening
HMIS	Health Management Information Systems
IAG	Immunisation Action Group
INR	Indian Rupee
JSI	John Snow, Inc
MoHFW	Ministry of Health and Family Welfare
NCCMIS	National Cold Chain Management Information System
NCCVMRC	National Cold Chain & Vaccine Management Resource Centre
NHM	National Health Mission
NUHM	National Urban Health Mission
PIP	Programme Implementation Plan
RCH	Reproductive Child Health portal
SVS	State Vaccine Store
UIP	Universal Immunisation Programme
USD	United States Dollars
VPD	Vaccine Preventable Disease
WIC	Walk in Cold room

Annex 2 : Methodology

Gavi's Audit and Investigations (A&I) audits are conducted in conformance with the Global Internal Audit Standards of the Institute of Internal Auditors. These Standards constitute the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the audit activity's performance. The Institute of Internal Auditors' Global Guidance is also adhered to as applicable to guide operations. In addition, A&I staff adhere to A&I's Audit Manual.

The principles and details of the A&I's audit approach are described in its Board-approved Terms of Reference and Audit Manual and specific terms of reference for each engagement. These documents help our auditors to provide high-quality professional work, and to operate efficiently and effectively. They help safeguard the independence of the A&I's auditors and the integrity of their work. The A&I's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

In general, the scope of A&I's work extends not only to the Gavi Secretariat but also to the programmes and activities carried out by Gavi's grant recipients and partners. More specifically, its scope encompasses the examination and evaluation of the adequacy and effectiveness of Gavi's governance, risk management processes, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve Stated goals and objectives.

Annex 3 : Definitions – audit opinion, audit rating and prioritisation

A. Overall Audit Opinion

The audit team ascribes an audit rating for each area/section reviewed, and the summation of these audit ratings underpins the overall audit opinion. The audit ratings and overall opinion are ranked according to the following scale:

Effective	**No issues or few minor issues noted**. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.
Partially Effective	**Moderate issues noted.** Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.
Needs significant improvement	**One or few significant issues noted.** Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet reasonable assurance that the objectives are likely to be met.
Ineffective	**Multiple significant and/or (a) material issue(s) noted.** Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised**.**

B. Issue Rating

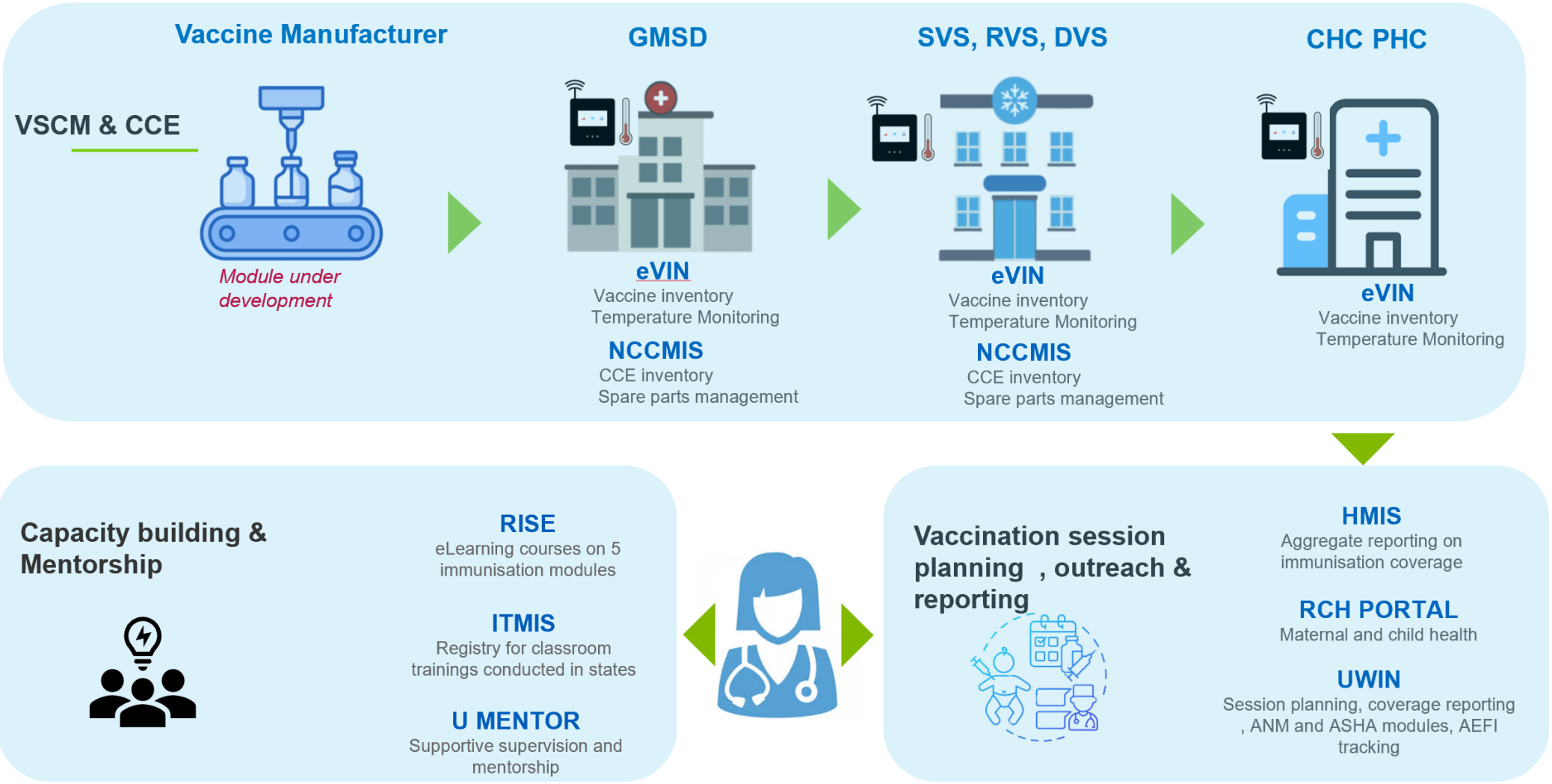
For ease of follow up and to enable management to focus effectively in addressing the issues in our report, we have classified the issues arising from our review in order of significance: High, Medium and Low. In ranking the issues between 'High,' 'Medium' and 'Low,' we have considered the relative importance of each matter, taken in the context of both quantitative and qualitative factors, such as the relative magnitude and the nature and effect on the subject matter. This is in accordance with the Committee of Sponsoring Organisations of the Treadway Committee (COSO) guidance and the Institute of Internal Auditors standards.

Rating	Implication
High	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating high inherent risks or strategic business risks are either inadequate or ineffective. • The issues identified may result in a risk materialising that could either have: a major impact on delivery of organisational objectives; major reputation damage; or major financial consequences. • The risk has either materialised or the probability of it occurring is very likely and the mitigations put in place do not mitigate the risk. • Fraud and unethical behaviour including management override of key controls. Management attention is required as a matter of priority.
Medium	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating medium inherent risks are either inadequate or ineffective. • The issues identified may result in a risk materialising that could either have: a moderate impact on delivery of organisational objectives; moderate reputation damage; or moderate financial consequences. • The probability of the risk occurring is possible and the mitigations put in place moderately reduce the risk. Management action is required within a reasonable time period.
Low	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating low inherent risks are either inadequate or ineffective. • The Issues identified could have a minor negative impact on the risk and control environment. • The probability of the risk occurring is unlikely to happen. Corrective action is required as appropriate.

Annex 4 : List of Facilities Visited

Provinces (9)	Districts (3)	Health Facilities (30)
Uttar Pradesh	Barabanki, Lucknow	Badagaon, Samudayik Swasthya Kendra Barabanki, Samudayik Swasthya Kendra Dariyabad, Indira Nagar UHC, Sarojini Nagar, Bakshi Ka Talab, Nawal Kishore Road, Ramsanehi
Bihar	Nalanda	Silao, Rajgir
Assam	Kamrup	Uparhali, Hajo, Dadara
Rajasthan	Sikar	SK Hospital, Nagwa, Palsana
Madhya Pradesh	Sehore	Rehti, Ichhawar, Budhni
Maharashtra	Pune, Thane	Dhasai, Fursungi, Kharbav, Mann, Kon, Vajreshwari
Odisha	Khurda	Chandrasekharpur, Mangalpur
Andhra Pradesh	Krishna	Chilakalapudi, Penamaluru, Kondapalli

Annex 5.1 : Overall System Landscape



Annex 5.2 : eVIN ROP Analysis

States / Union Territories	Amount as per NHM Budget (INR in million)	Amount yet to receive as per UNDP (INR in million)	Amount Received as per UNDP (INR in million)	Remarks as per UNDP letter to state in Dec 2024	MOA Status	Funding by CG
Andhra Pradesh	31.80	18.79		11.61 (2023/24); 13.82 (2024/25)	Expired MOA	60%
Andaman and Nicobar	3.60				Expired MOA	100%
Arunachal Pradesh	21.40		21.36		MOA Valid till March 2026	90%
Assam	30.10	9.32			Expired MOA	90%
Bihar	51.30		35.04		MOA Valid till March 2026	60%
Chandigarh	0.70	0.64			MOA Valid till March 2026	100%
Chhattisgarh	32.00	21.24		33.71 (2023-24)	Expired MOA	60%
Delhi	21.90		9.50		MOA Valid till March 2026	60%
Goa	1.80		1.50		No MOA	60%
Gujarat	30.30				No MOA	60%
Haryana	34.50	3.13	17.30		MOA Valid till March 2026	60%
Himachal Pradesh	17.10	5.12			No MOA	90%
J&K	20.30	8.67			No MOA	90%
Jharkhand	17.80	6.45			No MOA	60%
Karnataka	44.70	32.31		38.91 (2023/24); 24.49 (2024/25)	State to Exit	60%
Kerala	15.40	12.97			MOA Valid till March 2026	60%
Ladakh	2.90	0.42			MOA Valid till March 2026	100%
Lakshadweep	0.70		0.57		MOA Valid till March 2026	100%
Maharashtra	81.10	56.48			MOA Valid till March 2026	60%
Manipur	11.40	12.65			MOA Valid till March 2026	90%
Meghalaya	11.50		5.12		Expired MOA	90%
Mizoram	5.10	5.89			MOA Valid till March 2026	90%
Madhya Pradesh	58.00	49.61			Expired MOA	60%
Nagaland	7.50		4.42		MOA Valid till March 2026	90%
Odisha	10.50				No MOA	60%
Puducherry	1.90		3.50		MOA Valid till March 2026	60%
Punjab	33.20	12.69			MOA Valid till March 2026	60%
Rajasthan	61.20	27.34			MOA Valid till March 2026	60%
Sikkim	7.00	0.96	4.45		MOA Valid till March 2026	90%
Tamil Nadu	38.30		29.74		Expired MOA	60%
Telangana	24.20	3.42			No MOA	60%
Tripura	6.80	6.05			MOA Valid till March 2026	90%
Uttar Pradesh	103.50	91.71			Expired MOA	60%
Uttarakhand	36.60	11.34	14.42		Expired MOA	90%
West Bengal	21.80	18.44			MOA Valid till March 2026	60%
Dadra & Nagar Haveli and Daman & Diu			0.82		MOA Valid till March 2026	100%
Total (INR in million)	897.90	415.64	147.74			
Total (USD)	11,000,980	5,092,379	1,810,095			

Annex 6: Gaps in Vaccine Management

Annex 6.1: Reconciliation of Stock data in eVIN at GMSD

Vaccine Store	Vaccine	Expected Stock Balance	Actual stock balance	Variance
GMSD Karnal	Pentavalent vaccine	1,221,240	2,040	1,219,200
	Inactivated Polio vaccine	620,420	1,740,475	(1,120,055)
	Pneumococcal Conjugate Vaccine	1,499,500	162,500	1,337,000
	Measles and Rubella	6,680,450	2,934,525	3,745,925
	BCG	9,026,260	2,077,260	6,949,000

Annex 6.2: Reconciliation of Stock data in eVIN at SVS

Vaccine Store	Vaccine	Expected Stock Balance	Actual stock balance	Variance
Pune SVS	Pentavalent vaccine	-385,790	140,000	(525,790)
	Inactivated Polio vaccine	-5,590,250	1,168,750	(6,759,000)
	Pneumococcal Conjugate Vaccine	379,625	1,774,625	(1,395,000)
	Measles and Rubella	261,440	426,500	(165,060)
	BCG	512,000	362,000	150,000
Odisha SVS	Inactivated Polio vaccine	206,000	190,000	16,000
	Pneumococcal Conjugate Vaccine	675,320	994,320	(319,000)
	BCG	1,077,000	77,000	1,000,000
	BCG	455,500	447,500	8,000
Andra Pradesh SVS	Inactivated Polio vaccine	82,500	85,000	(2,500)
	Measles and Rubella	-20,000	2,050	(22,050)

Annex 6.3: Reconciliation of Stock data in eVIN at DVS

Vaccine Store	Vaccine	Expected Stock Balance	Actual stock balance	Variance
Bhubaneswar DVS	Pneumococcal Conjugate Vaccine	-3,750	1,200	(4,950)
	Measles and Rubella	200	625	(425)
Sehore DVS	Inactivated Polio vaccine	13675	13775	(100)
Barabanki DVS	Pentavalent vaccine	10560		10,560
	Pneumococcal Conjugate Vaccine	6000		6,000
	Measles and Rubella	2500		2,500
Pune DVS	Pentavalent vaccine	-1100	25850	(26,950)
	Inactivated Polio vaccine	100975	125900	(24,925)
	Pneumococcal Conjugate Vaccine	4575	5425	(850)
	Measles and Rubella	7680	27350	(19,670)
	BCG	12070	55430	(43,360)
Krishna DVS	Pentavalent vaccine	30000	7880	22,120

Annex 6.4: Variances between Physical Count and Stock balances in eVIN at GMSD

Vaccine Store	Name of Vaccine	Batch No.	Quantity counted (A)	Quantity recorded in eVIN (B)	Variance (A-B)
Karnal GMSD	Measles and Rubella	0113N085A	134,525	5,000	129,525
	BCG	L213	-	3,000	(3,000)

Annex 6.5: Variances between Physical Count and Stock balances in eVIN at SVS

Vaccine Store	Name of Vaccine	Batch No.	Quantity counted	Quantity recorded in eVIN	Variance
Assam SVS	IPV	IPQ027A23	532,675	567,675	(35,000)

Annex 6.6: Variances between Physical Count and Stock balances in eVIN at DVS

Vaccine Store	Name of Vaccine	Batch No.	Quantity counted	Quantity recorded in eVIN	Variance
Thane DVS	Pentavalent vaccine	220115824A	4560	5300	(740)
		220117424A	2400	1640	760
	Measles and Rubella	228105624A	500	215	285
		228106424A	8395	8680	(285)
	BCG	0373MA045		34500	(34,500)
		0373MA080		500	(500)
		GSV124030		12870	(12,870)
Pune DVS	Pentavalent vaccine	220117424A	19680	19500	180
	Inactivated Polio vaccine (IPV)	IPQ014A23	13300	13400	(100)

Annex 6.7: Variances between Physical Count and Stock balances in eVIN at CCPs

CHC – PHC	Name of Vaccine	Batch No.	Quantity counted	Quantity recorded in eVIN	Variance
Community Health Centre, Bakshi Ka Talab	Pentavalent vaccine	220111724A	0	60	(60)
	Inactivated Polio vaccine	IPQ020A23	0	50	(50)
		IPQ028A23	500	625	(125)
	Pneumococcal Conjugate Vaccine	421513124A	60	195	(135)
	Measles and Rubella	228104224A	310	415	(105)
	BCG	GSV124023	380	540	(160)
Kharbav PHC	Inactivated Polio vaccine	1934Q011	50	100	(50)
Dhasai PHC	Pentavalent vaccine	220115824A	70	80	(10)
	Inactivated Polio vaccine	1934Q006	0	50	(50)
		IPQ014A23	25	0	25
	Pneumococcal Conjugate Vaccine	2093Y026C	50	40	10
		2093AA031	0	20	(20)
	Measles and Rubella	228106424A	5	15	(10)
	BCG	L172	10	130	(120)
		0373MA045	100	0	100
Fursungi PHC	Pentavalent vaccine	22115824A	280	330	(50)
	Inactivated Polio vaccine	IPQO14423	1225	1275	(50)
	Pneumococcal Conjugate Vaccine	68B24014A	1260	1360	(100)
	Measles and Rubella	0113NO79A	550	615	(65)
	BCG	LI72	50	10	40
		0373MA077	5900	5950	(50)
CHC Silao	Pentavalent vaccine	220106024A	380	370	10
Kon PHC	Pentavalent vaccine	220115824A	180	290	(110)
	Inactivated Polio vaccine	IPQ014A23	475	500	(25)
	Pneumococcal Conjugate Vaccine	2093Y027B	405	295	110
		2093AA032	0	80	(80)

CHC – PHC	Name of Vaccine	Batch No.	Quantity counted	Quantity recorded in eVIN	Variance
	Measles and Rubella	228106424A	385	400	(15)
		0112N81A	0	40	(40)
	BCG	0373MA045	500	0	500
		0373MA080	50	600	(550)
		L171	10	0	10
		GSV-017/22	10	0	10
Samudayik Swasthya Kendra (CHC), Dariyabad	Measles and Rubella	228104324A	300	305	(5)
	BCG	GSV07023	490	500	(10)
	Measles and Rubella	228104324A	415	420	(5)
Penamaluru PHC	Inactivated Polio vaccine	IPQ019A23	725	25	700
		IPQ018A23	25	725	(700)
	Measles and Rubella	228107024A	500	550	(50)
		228100124A	405	190	215
		0113N076B		165	(165)
Civil Hospital Block Ichhawar	Pentavalent vaccine	220115824A	330	340	(10)
	Pneumococcal Conjugate Vaccine	421503724A	525	535	(10)
	Measles and Rubella	228100624A	0	40	(40)
		228100724A	510	480	30
CHC Rehti	Measles and Rubella	228100624A	200	205	(5)
	BCG	L197	250	260	(10)
Chilakalapudi UPHC, Machilipatnam, Krishna Dist.	Inactivated Polio vaccine	IPQ018A23	175	150	25
		IPQ019A23	125		125
		IPQ014A23	50		50
		I934T003		200	(200)
	Measles and Rubella	228107024A	85	90	(5)
		0114M013A	120	115	5
Chandrasekharpur UPHC	Pneumococcal Conjugate Vaccine	421506324A	310	300	10
		421504024A	45	55	(10)
	Measles and Rubella	0113N078A	250	290	(40)
		0113N077B	40		40
Mangalpur CHC	Pentavalent vaccine	220108424A	30		30
		220116924A	110	140	(30)
	Inactivated Polio vaccine	IPQ021A23	25	75	(50)
		IPQ017A23	50		50
	Pneumococcal Conjugate Vaccine	421505024A	70	90	(20)
		421506324A	100	200	(100)
		421509324A	10		10
		421502024A	5		5
		421504024A	125		125
	Measles and Rubella	0114N003A	100		100
		0113N078A	60	175	(115)
		0113N077A	10		10
	BCG	0374MA045	200	150	50
		GSV06923	20		20
		0374MA016		50	(50)
		GSV124018	180	200	(20)
Community Health Centre-Budhni	Pneumococcal Conjugate Vaccine	421503724A	240	30	210
		421504224A	30	240	(210)
	Measles and Rubella	228100724A	250	140	110
		0113W058	325	500	(175)
		0113W034	20		20
		228100624A	45		45
Urban Community Health Centre - Nawal Kishore Road	Pentavalent vaccine	228102424A	245	285	(40)
	BCG	GSB124023	960	1040	(80)

CHC – PHC	Name of Vaccine	Batch No.	Quantity counted	Quantity recorded in eVIN	Variance
Singimari Dadara Model Hospital (Dadara MPHC)	Pentavalent Vaccine	24GPEN010	80	90	(10)
Maan CHC	Pneumococcal Conjugate Vaccine	2093AA031	750	2090	(1,340)
	Measles and Rubella	0113n079A	1000	1020	(20)
Urban Community Health Centre- Indira Nagar, Lucknow	Pentavalent vaccine	220111724A	10	30	(20)
	Inactivated Polio vaccine	IPQ028A23	200	575	(375)
		4211513224A	0	240	(240)
	Measles and Rubella	228104224A	180	515	(335)
	BCG	GSV124023	660	1030	(370)
Vajreshwari PHC	Pentavalent vaccine	220115824A	260	290	(30)
	Inactivated Polio vaccine	1PQ014A23	20	75	(55)
		1934Q011	25	0	25
	Pneumococcal Conjugate Vaccine	2093Y026C	85	0	85
		2093Y027B	265	245	20
	Measles and Rubella	228106424A	100	125	(25)
	BCG	0373MA045	420	480	(60)
Uparhali Block PHC	Measles and Rubella	0113W038	125	120	5
Bishnuram Medhi Community Health Centre, Hajo (Hajo BPHC)	Pneumococcal Conjugate Vaccine	2094Y001A	860	605	255
		2093Y035A	0	255	(255)

Annex 6.8: CCE Inventory at GMSD

GMSD	Harmonised Equipment Classification	Equipment was Functional	Equipment was registered in NCCMIS	Equipment was connected to an eVIN temperature logger	eVIN temperature logger was functional
Karnal	Walk in Freezer Room	NO	YES		
	Walk in Freezer Room	NO	YES		
	Walk in Freezer Room	YES	YES		
Mumbai	Walk in Cold Room	YES	NO	YES	YES
	Walk in Cold Room	YES	NO	YES	YES
	Walk in Cold Room	YES	NO	YES	NO
	Walk in Cold Room	YES	NO	YES	YES
	Walk in Cold Room	YES	NO	YES	NO
	Walk in Cold Room	YES	NO	YES	NO
	Walk in Cold Room	YES	NO	YES	NO
	Walk in Freezer Room	YES	NO	YES	NO
	Walk in Freezer Room	YES	NO	YES	NO
	Walk in Freezer Room	YES	NO	YES	NO
	Walk in Freezer Room	YES	NO	YES	NO
	Walk in Freezer Room	YES	NO	YES	NO

Summary

CCE Functional	21	91%
CCE non-functional	2	9%
CCE registered in NCCMIS	11	48%
CCE not registered in NCCMIS	12	52%
WICRs & WIFRs with vaccines connected to Temperature logger	20	100%
WICRs & WIFRs with vaccines not connected to Temperature logger	0	0%
Functional Temperature loggers	11	55%
Non-functional Temperature loggers	9	45%

Annex 6.9: CCE Inventory at SVS

Vaccine Store	Harmonised Equipment Classification	Equipment was Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger was functional
Pune SVS	Walk in Cold Room	YES	NO	YES	YES
	Walk in Freezer Room	YES	YES		
Assam SVS	Walk in Cold Room	YES	YES	YES	NO
	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Ice Lined Refrigerator	YES	NO	NO	N/A
	Ice Lined Refrigerator	YES	NO	NO	N/A
Lucknow SVS	Walk in Freezer Room	YES	YES		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
Odisha SVS	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
Bhopal SVS	Walk in Cold Room	YES	YES	NO	N/A
	Walk in Cold Room	NO	YES	YES	YES
	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
Bihar SVS	Walk in Cold Room	YES	YES	YES	NO
	Walk in Cold Room	YES	YES	YES	NO
	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
Andhra Pradesh SVS	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
	Walk in Freezer Room	YES	YES		
Rajasthan SVS	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Walk in Cold Room	NO	YES	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Walk in Freezer Room	NO	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		

Vaccine Store	Harmonised Equipment Classification	Equipment was Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger was functional
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Walk in Cold Room	YES	YES	NO	N/A
	Walk in Cold Room	NO	YES	NO	N/A
	Walk in Cold Room	YES	YES	NO	N/A
	Walk in Cold Room	YES	YES	NO	N/A
	Ice Lined Refrigerator	NO	YES	NO	N/A
	Ice Lined Refrigerator	NO	YES	NO	N/A

Summary

CCE Functional	**71**	**92%**
CCE non-functional	**6**	**8%**
CCE registered in NCCMIS	**65**	**84%**
CCE not registered in NCCMIS	**12**	**16%**
WICRs & ILRs with vaccines connected to Temperature logger	**31**	**76%**
WICRs & ILRs with vaccines not connected to Temperature logger	**10**	**24%**
Functional Temperature loggers	**28**	**90%**
Non-functional Temperature loggers	**3**	**10%**

Annex 6.10: CCE data at DVS

Vaccine Store	Harmonised Equipment Classification	Equipment Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger functional
Sikar DVS	Ice Lined Refrigerator	NO	YES	NO	N/A
	Ice Lined Refrigerator	NO	NO	NO	N/A
	Ice Lined Refrigerator	NO	YES	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	NO	YES		
	Deep Freezer	NO	YES		
Bhubaneswar DVS	Ice Lined Refrigerator	NO	YES	YES	N/A
	Deep Freezer	YES	YES		
Sehore DVS	Ice Lined Refrigerator	YES	YES	NO	N/A
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Barabanki DVS	Ice Lined Refrigerator	YES	YES	N/A	N/A

Vaccine Store	Harmonised Equipment Classification	Equipment Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger functional
	Ice Lined Refrigerator	YES	YES	N/A	N/A
	Ice Lined Refrigerator	YES	YES	N/A	N/A
	Ice Lined Refrigerator	YES	YES	N/A	N/A
	Ice Lined Refrigerator	YES	YES	N/A	N/A
	Ice Lined Refrigerator	YES	YES	YES	YES
	Ice Lined Refrigerator	YES	YES	N/A	N/A
	Ice Lined Refrigerator	YES	YES	N/A	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	NO	YES		
	Deep Freezer	NO	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Kamrup (Rural) DVS	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	YES		
	Deep Freezer	NO	YES		
	Ice Lined Refrigerator	YES	NO	YES	YES
Pune DVS	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	NO	YES
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	YES	NO
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	NO	N/A
	Ice Lined Refrigerator	YES	NO	NO	N/A
	Ice Lined Refrigerator	YES	NO	NO	N/A
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
Krishna DVS	Ice Lined Refrigerator	NO	YES	N/A	N/A
	Deep Freezer	YES	YES		
Nalanda DVS	Deep Freezer	NO	YES		
	Deep Freezer	NO	YES		
	Deep Freezer	NO	YES		
	Deep Freezer	YES	NO		
	Deep Freezer	YES	NO		
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Ice Lined Refrigerator	NO	YES	N/A	N/A
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	NO	NO	N/A

Vaccine Store	Harmonised Equipment Classification	Equipment Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger functional
Thane DVS	Ice Lined Refrigerator	YES	YES	YES	NO
	Ice Lined Refrigerator	YES	YES	YES	NO
	Deep Freezer	YES	YES		

Summary

CCE Functional	117	89%
CCE non-functional	14	11%
CCE registered in NCCMIS	109	83%
CCE not registered in NCCMIS	22	17%
ILR with vaccines connected to Temperature logger	75	87%
ILR with vaccines not connected to Temperature logger	11	13%
Functional Temperature loggers	72	96%
Nonfunctional Temperature loggers	3	4%

Annex 6.11: CCE at Cold chain points

Cold chain points	Harmonised Equipment Classification	Equipment was Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger was functional
Kon PHC	Ice Lined Refrigerator	YES	YES	YES	NO
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
Badagaon CHC	Ice Lined Refrigerator	YES	N/A	YES	YES
	Ice Lined Refrigerator	YES	N/A	YES	YES
	Ice Lined Refrigerator	YES	N/A	YES	YES
Community Health Centre, Sarojini Nagar	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Samudayik Swasthya Kendra (CHC), Dariyabad	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Samudayik Swasthya Kendra, Dewa	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Fursungi PHC	Deep Freezer	YES	YES		
Penamaluru PHC	Deep Freezer	YES	YES		
	Ice Lined Refrigerator	YES	YES	NO	NO
Civil Hospital Block Ichhawar	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
CHC Rehti	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Kondapalli PHC	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
Nagwa CHC	Deep Freezer	YES	YES		
Palsana PHC	Deep Freezer	YES	YES		

Cold chain points	Harmonised Equipment Classification	Equipment was Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger was functional
S.K. Hospital, MCH Wing Janana, Sikar	Deep Freezer	YES	YES		
Chilakalapudi UPHC, Machilipatnam, Krishna Dist.	Deep Freezer	YES	YES		
Dhasai PHC	Ice Lined Refrigerator	YES	NO	YES	YES
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Ice Lined Refrigerator	NO	NO	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	NO	YES		
Kharbav PHC	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
Mangalpur CHC	Ice Lined Refrigerator	YES	YES	NO	N/A
Community Health Centre-Budhni	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
Community Health Centre, Bakshi Ka Talab	Ice Lined Refrigerator	YES	N/A	NO	N/A
	Ice Lined Refrigerator	YES	N/A	YES	YES
	Ice Lined Refrigerator	YES	N/A	YES	YES
	Deep Freezer	YES	N/A		
	Deep Freezer	YES	N/A		
	Deep Freezer	YES	N/A		
	Deep Freezer	YES	N/A		
Urban Community Health Centre - Nawal Kishore Road	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	N/A	YES		
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	N/A	YES		
	Ice Lined Refrigerator	YES	YES	NO	N/A
Hajo BPHC	Deep Freezer	N/A	YES		
	Deep Freezer	YES	YES		
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Ice Lined Refrigerator	N/A	YES	N/A	N/A
	Ice Lined Refrigerator	YES	NO	YES	YES
Rajgiri PHC	Deep Freezer	YES	YES		
	Ice Lined Refrigerator	NO	YES	N/A	N/A
	Ice Lined Refrigerator	YES	NO	N/A	N/A
Uparhali Block PHC	Deep Freezer	NO	YES		
	Ice Lined Refrigerator	N/A	YES	N/A	N/A
	Deep Freezer	YES	NO		
	Deep Freezer	NO	NO		
CHC Silao	Deep Freezer	YES	YES		
	Ice Lined Refrigerator	YES	YES	NO	N/A
	Ice Lined Refrigerator	NO	YES	NO	N/A
Dadara MPHC	Deep Freezer	YES	YES		
	Ice Lined Refrigerator	YES	YES	NO	N/A
Maan CHC	Ice Lined Refrigerator	YES	YES	NO	YES
Ramsanehi Ghat CHC	Ice Lined Refrigerator	YES	N/A	YES	YES
	Ice Lined Refrigerator	YES	N/A	YES	YES
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		

Cold chain points	Harmonised Equipment Classification	Equipment was Functional	Equipment registered in NCCMIS	Equipment connected to an eVIN temperature logger	eVIN temperature logger was functional
Urban Community Health Centre- Indira Nagar, Lucknow	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	YES	YES		
	Deep Freezer	NO	YES		
	Deep Freezer	YES	YES		
Vajreshwari PHC	Ice Lined Refrigerator	YES	NO	YES	NO
	Ice Lined Refrigerator	YES	YES	NO	NO
	Ice Lined Refrigerator	NO	YES	NO	NO
	Deep Freezer	NO	YES		

Summary

CCE Functional	111	92.5%
CCE non-functional	9	7.5%
CCE registered in NCCMIS	106	94%
CCE not registered in NCCMIS	7	6%
ILRs with vaccines connected to Temperature logger	44	70%
ILR with vaccines not connected to Temperature logger	19	30%
Functional Temperature loggers	43	90%
Non-functional Temperature loggers	5	10%

Annex 7: Discrepancies in data between HMIS, UWIN and eVIN

Health Facility	Month	No. of immunisations (a)	No. of immunisations (b)	No. of doses dispensed in eVIN (c)	Variance *(b-a)*	Variance *(c-a)*
Palsana PHC	Dec-24	82	10	140	(72)	58
	Jan-25	63	14	130	(49)	67
	Feb-25	53	8	120	(45)	67
Community Health Centre, Bakshi Ka Talab	Dec-24	808	358	710	(450)	(98)
	Jan-25	743	541	610	(202)	(133)
	Feb-25	882	541	1060	(341)	178
Community Health Centre, Sarojini Nagar	Dec-24	1604	1318	1440	(286)	(164)
	Jan-25	1471	1381	1710	(90)	239
	Feb-25	1680	1572	1880	(108)	200
Kharbav PHC	Dec-24	459	107		(352)	
	Jan-25	519	237		(282)	
	Feb-25	494	313		(181)	
Dhasai PHC	Dec-24	60	3	70	(57)	10
	Jan-25	71	24	230	(47)	159
	Feb-25	54	36	60	(18)	6
Community Health Centre- Budhni	Dec-24	231	347	260	116	29
	Jan-25	236	454	370	218	134
	Feb-25	227	403	270	176	43
CHC Silao	Dec-24	930	931	793	1	(137)
	Jan-25	1086	1086	1010	0	(76)
	Feb-25	1019	1019	974	0	(45)
Badagaon CHC	Dec-24	1183	630	840	(553)	(343)
	Jan-25	1356	826	1260	(530)	(96)
	Feb-25	1275	881	1060	(394)	(215)
Community Health Centre, Sarojini Nagar	Dec-24	1604	1318	1440	(286)	(164)
	Jan-25	1471	1381	1710	(90)	239
	Feb-25	1680	1572	1880	(108)	200
Samudayik Swasthya Kendra (CHC), Dariyabad	Dec-24	1362	809	1490	(553)	128
	Jan-25	1368	815	1390	(553)	22
	Feb-25	1362	906	1430	(456)	68

Health Facility	Month	No. of immunisations (a)	No. of immunisations (b)	No. of doses dispensed in eVIN (c)	Variance *(b-a)*	Variance *(c-a)*
Samudayik Swasthya Kendra, Dewa	Dec-24	1419	1143	1360	(276)	(59)
	Jan-25	1503		1290		(213)
	Feb-25	1508	1189	1400	(319)	(108)
Civil Hospital Block Icchawar	Dec-24	123	100	540	(23)	417
	Jan-25	110	383	510	273	400
	Feb-25	132	542	530	410	398
CHC Rehti	Dec-24	66	74	250	8	184
	Jan-25	66	90	250	24	184
	Feb-25	81	478	200	397	119
Community Health Centre-Budhni	Dec-24	231	347	260	116	29
	Jan-25	236	454	370	218	134
	Feb-25	227	403	270	176	43
Community Health Centre, Bakshi Ka Talab	Dec-24	808	358	710	(450)	(98)
	Jan-25	743	541	610	(202)	(133)
	Feb-25	882	541	1060	(341)	178
Urban Community Health Centre - Nawal Kishore Road	Dec-24	1271	774	1060	(497)	(211)
	Jan-25	1196	1021	1090	(175)	(106)
	Feb-25	1292	1199	1340	(93)	48
Hajo BPHC	Dec-24	504	349	520	(155)	16
	Jan-25	531	406	540	(125)	9
	Feb-25	581	517	790	(64)	209
Sub- divisional Hospital, Rajgiri (PHC)	Dec-24	807	750	770	(57)	(37)
	Jan-25	853	825	940	(28)	87
	Feb-25	864	836	880	(28)	16
Uparhali Block PHC	Dec-24	62	46	70	(16)	8
	Jan-25	59	32	90	(27)	31
	Feb-25	66	62	100	(4)	34
CHC Silao	Dec-24	931	793	890	(138)	(41)
	Jan-25	1086	1010	1080	(76)	(6)
	Feb-25	1019	974	900	(45)	(119)
Singimari Dadara Model Hospital (Dadara MPHC)	Dec-24	63	57	110	(6)	47
	Jan-25	77	50	90	(27)	13
	Feb-25	80	62	100	(18)	20
Maan CHC	Dec-24	112	29	2800	(83)	2,688
	Jan-25	94	37	260	(57)	166
	Feb-25	120	50	1540	(70)	1,420
Ramsanehi Ghat CHC	Dec-24	1528	908	990	(620)	(538)
	Jan-25	1438	978	1040	(460)	(398)
	Feb-25	1567	974	1180	(593)	(387)
Urban Community Health Centre- Indira Nagar, Lucknow	Dec-24	1293	842	1360	(451)	67
	Jan-25	1539	1148	1490	(391)	(49)
	Feb-25	1679	1340	1680	(339)	1
Vajreshvari_PHC	Dec-24	120	67	140	(53)	20
	Jan-25	141	83	160	(58)	19
	Feb-25	147	86	130	(61)	(17)
S.K. Hospital, MCH Wing Janana, Sikar	Dec-24	72	11	100	(61)	28
	Jan-25	100	14	100	(86)	0
	Feb-25	66	8	100	(58)	34
Fursungi PHC*	Dec-23	103	0	820	(103)	717
	Jan-25	110	0	440	(110)	330
	Feb-25	93	0	520	(93)	427
Kon PHC	Dec-24	400	257	510	(143)	110
	Jan-25	367	359	450	(8)	83
	Feb-25	399	453	450	54	51
Penamaluru PHC	Dec-23	861	668	880	(193)	19
	Jan-25	491	456	540	(35)	49
	Feb-25	502	437	500	(65)	(2)
Kondapalli PHC	Dec-24	180	321	0	141	(180)
	Jan-25	1991	1567	2158	(424)	167
	Feb-25	2875	2291	3121	(584)	246
Mangalpur CHC	Dec-24	119	217	130	98	11

Health Facility	Month	No. of immunisations (a)	No. of immunisations (b)	No. of doses dispensed in eVIN (c)	Variance *(b-a)*	Variance *(c-a)*
	Jan-25	123	215	110	92	(13)
	Feb-25		250	140	250	140
Chandrasekharpur UPHC	Dec-24	64	12	40	(52)	(24)
	Jan-25	81	21	230	(60)	149
	Feb-25		37	190	37	190
Nagwa CHC**	Dec-24	68	0	40	(68)	(28)
	Jan-25	65	0	80	(65)	15
	Feb-25	57	9	50	(48)	(7)
Chilakalapudi UPHC	Dec-24	23	11	30	(12)	7
	Jan-25	11	6	20	(5)	9
	Feb-25	69	51	90	(18)	21
Total		**63,978**	**50,460**	**69,916**	**(13,518)**	**5,938**

** Health facility in Maharashtra started using UWIN in March 2025*
*** Health facility in Rajasthan started using UWIN in February 2025*

Data not provided

Variance between HMIS and UWIN data	21%

Incidences where # of vaccinations recorded in HMIS exceeded the recorded vaccine consumption in eVIN	32	33%
	66	67%

Annex 8: Details of PEF TCA funding

PEF TCA	2022 (USD)	2023 (USD)	2024 (USD)	Grand Total (USD)
UNICEF	*249,178*	-	-	*249,178*
WHO	*254,419*	-	-	*254,419*
Total	***503,597***	**-**	**-**	***503,597***

Annex 9: Scope of work for Government agencies and CSO operating in the same states

State	CSO	Government Agency
Assam	VHAI • Social Mapping; Identification of ZD children and local influencers / local CBOs and their capacity building • Integrate ZD children in micro plans and facilitate house to house engagements • Support community facilitator and community health officer • Participate in review meetings	NRHM Dibrugarh • The district level activities for CAB and Vaccine promotion which required support of the coordinator planning, networking and convergence, capacity building, social mobilisation, supportive supervision and documentation and reporting. • Technical support for RMNCH+A & RI in NE states which includes activities like Monitoring of CVS and RI, mobilisation activities in rural and urban areas, stakeholders meeting on CAB.
Rajasthan	Manjari Sansthan • Identification of zero-dose children/communities and their inclusion in micro plan	Aravali

State	CSO	Government Agency
	• Development and strengthening of a functional, sustainable system for community supported tracking of zero dose children, • Identification of local influencers and their capacity building, enhancing capacities of right holders, • Enhancing knowledge, attitude and skills of health functionaries, • Strengthening data management concerning zero dose children	• Collection of community based evidence under end line plan in low immunisation area of Karauli district
Uttar Pradesh	PCI and JSI • Training and orientation to FLWs • Social mapping • Attending review meetings • Orientation of panchayat leaders and ward members • Orientation of community-based networks • Mobilisation of social media influencers for immunisation: • Documentation and Knowledge management • Sustainability and follow-up with influencers, FLWs and networks	KGMU Lucknow • Extension of financial support for "Technical assistance for routine immunisation with focused support to reach Zero Dose (ZD) children and Missed Communities in identified geographies/districts of Uttar Pradesh and RMNCH+A strengthening with focus on zero dose communities through Divisional Consultants"

Annex 10: Questioned Costs

Digital Empowerment Foundation

Voucher n°	Voucher Date	Grant	Transaction description	Amount in supporting documents	Inadequate	Ineligible
2504	23-Feb-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for various themes announcements	387,400	387,400	-
2779	16-Mar-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for various themes announcements	26,520	26,520	-
410	16-Jun-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for various themes announcements	152,400	152,400	-
624	7-Jul-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for various themes announcements	313,400	313,400	-
684	29-Jul-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for various themes announcements	178,000	178,000	-
2197/2229	31-Jan-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	20,000	20,000	-
2511	24-Feb-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	16,000	16,000	-
2576	28-Feb-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	4,000	4,000	-
2856	31-Mar-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	20,000	20,000	-
122	30-Apr-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	20,000	20,000	-
320	31-May-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	20,000	20,000	-
476	30-Jun-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	20,000	20,000	-
634	9-Jul-22	UNICEF-RCCE-II	Accountant's Salary - Irshad	5,806	5,806	-
2403	31-Jan-22	UNICEF-RCCE-II	Social Listening Toolkit - Rapid Pro Chatbot (Online & Offline medium)	30,000	30,000	-
2709	28-Feb-22	UNICEF-RCCE-II	Social Listening Toolkit - Rapid Pro Chatbot (Online & Offline medium)	30,000	30,000	-
3064	31-Mar-22	UNICEF-RCCE-II	Social Listening Toolkit - Rapid Pro Chatbot (Online & Offline medium)	30,000	30,000	-
142	30-Apr-22	UNICEF-RCCE-II	Social Listening Toolkit - Rapid Pro Chatbot (Online & Offline medium)	30,000	30,000	-
2504	23-Feb-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for community meetings	302,940	302,940	-
2779	16-Mar-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for community meetings	30,072	30,072	-
410	16-Jun-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for community meetings	116,820	116,820	-
624	7-Jul-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for community meetings	255,600	255,600	-
684	29-Jul-22	UNICEF-RCCE-II	Consultancy Expense Payment to the volunteers for community meetings	131,220	131,220	-
2259	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2314	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2317	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2332	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-

Voucher n°	Voucher Date	Grant	Transaction description	Amount in supporting documents	Inadequate	Ineligible
2346	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2350	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2409	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	156,000	156,000	-
2569	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	7,800	7,800	-
2587	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2599	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2603	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2705	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	156,000	156,000	-
2706	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
2707	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	5,200	5,200	-
2708	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3012	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3040	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3041	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3051	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3057	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3059	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
3072	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	130,000	130,000	-
3101	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator- Sindhu Devi for the month of March	13,000	13,000	-
3102	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator- Suchitra V for the month of March	13,000	13,000	-
103	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
106	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
118	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
130	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
134	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
158	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	156,000	156,000	-
71	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
268	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
276	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
305	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
317	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	11,952	11,952	-

Voucher n°	Voucher Date	Grant	Transaction description	Amount in supporting documents	Inadequate	Ineligible
327	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
331	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
353	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	39,000	39,000	-
357	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	117,000	117,000	-
466	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	12,568	12,568	-
468	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	143,000	143,000	-
469	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
470	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
471	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
473	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
478	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
479	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
630	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	3,774	3,774	-
632	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	46,165	46,165	-
633	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	4,822	4,822	-
635	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	10,916	10,916	-
636	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	13,000	13,000	-
637	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator of Jijaz hussain	3,774	3,774	-
638	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the District Coordinator	7,548	7,548	-
2240	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
2333	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
2334	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
2512	24-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	28,000	28,000	-
2513	24-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	28,000	28,000	-
2514	24-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	28,000	28,000	-
2573	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	7,000	7,000	-
2588	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	7,000	7,000	-
2589	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	7,000	7,000	-
2858	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
2948	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
3052	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-

Voucher n°	Voucher Date	Grant	Transaction description	Amount in supporting documents	Inadequate	Ineligible
112	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
119	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
120	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
309	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
318	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
319	31-May-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
472	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
474	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
475	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	35,000	35,000	-
631	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	10,161	10,161	-
639	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	10,161	10,161	-
640	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment to the Program Coordinator	10,161	10,161	-
2344	31-Jan-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	20,000	20,000	-
2515	24-Feb-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	16,000	16,000	-
2598	28-Feb-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	4,000	4,000	-
3056	31-Mar-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	20,000	20,000	-
129	30-Apr-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	20,000	20,000	-
326	31-May-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	20,000	20,000	-
477	30-Jun-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	20,000	20,000	-
641	9-Jul-22	UNICEF-RCCE-II	Salary Expense Payment of Salary to the Executive of Communication & Media Department	5,806	5,806	-
199	2-May-22	UNICEF-RCCE-II	Workshop & Training Expense Video coverage and photography of the programme	340,000	-	51,864
Total			 Gavi contribution – 46.745%	**4,758,986**	**4,418,986** **2,065,670**	**51,864** **24,244**

Ayaan Welfare Society

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
7.1.1.- Hiring of LED 50 Inches						
17	26-05-2022	COVID-19	Hiring of LED TV 50 Inches		150,000	150,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
21	26-05-2022	COVID-19	Hiring of LED TV 50 Inches		150,000	150,000
53	26-05-2022	COVID-19	Hiring of LED TV 50 Inches		150,000	150,000
71	26-05-2022	COVID-19	Hiring of LED TV 50 Inches		450,000	450,000
78	28-06-2022	COVID-19	Hiring of LED TV 50 Inches		450,000	450,000
7.1.2 - Hiring of PA System						
10	17-05-2022	COVID-19	Hiring of PA System		120,000	120,000
25	17-05-2022	COVID-19	Hiring of PA System		120,000	120,000
68	17-05-2022	COVID-19	Hiring of PA System		120,000	120,000
72	17-05-2022	COVID-19	Hiring of PA System		360,000	360,000
79	17-05-2022	COVID-19	Hiring of PA System		360,000	360,000
7.1.3 - Hiring of Portable Generators to run TV & System						
14	07-03-2022	COVID-19	Hiring of portable Generator to run TV & PA System		250,000	250,000
28	21-07-2022	COVID-19	Hiring of portable Generator to run TV & PA System		250,000	250,000
59	21-07-2022	COVID-19	Hiring of portable Generator to run TV & PA System		250,000	250,000
73	18-08-2022	COVID-19	Hiring of portable Generator to run TV & PA System		750,000	750,000
80	10-08-2022	COVID-19	Hiring of portable Generator to run TV & PA System		750,000	750,000
7.1.6 - Hiring of Vehicle						
16	26-05-2022	COVID-19	Hiring Vehicle (pick up/ Bolero) with driver		230,000	230,000
32	26-05-2022	COVID-19	Hiring Vehicle (pick up/ Bolero) with driver		230,000	230,000
65	26-05-2022	COVID-19	Hiring Vehicle (pick up/ Bolero) with driver		230,000	230,000
74	26-05-2022	COVID-19	Hiring Vehicle (pick up/ Bolero) with driver		690,000	690,000
81	21-06-2022	COVID-19	Hiring Vehicle (pick up/ Bolero) with driver		690,000	690,000
7.1.7- PoL for Vehicles						
18	26-05-2022	COVID-19	Program output 7 PoL for Vehicles		250,000	250,000
36	26-05-2022	COVID-19	Program output 7 PoL for Vehicles		250,000	250,000
61	26-05-2022	COVID-19	Program output 7 PoL for Vehicles		250,000	250,000
75	26-05-2022	COVID-19	Program output 7 PoL for Vehicles		750,000	750,000
82	21-06-2022	COVID-19	Program output 7 PoL for Vehicles		750,000	750,000
7.1.8- Hiring of Facilitators						
7	01-05-2022	COVID-19	Program output 7: Hiring of Facilitators		6,500	6,500

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
39	16-05-2022	COVID-19	Program output 7: Hiring of Facilitators		7,000	7,000
69	23-06-2022	COVID-19	Program output 7: Hiring of Facilitators		445,500	445,500
76	23-06-2022	COVID-19	Program output 7: Hiring of Facilitators		445,500	445,500
83	23-06-2022	COVID-19	Program output 7: Hiring of Facilitators		445,500	445,500
7.1.9 - Hiring of Support staff						
9	24-03-2022	COVID-19	Program output 7: Hiring of Support staff		80,000	80,000
45	15-04-2022	COVID-19	Program output 7: Hiring of Support staff		87,700	87,700
67	20-05-2022	COVID-19	Program output 7: Hiring of Support staff		105,000	105,000
77	28-06-2022	COVID-19	Program output 7: Hiring of Support staff		270,000	270,000
84	28-06-2022	COVID-19	Program output 7: Hiring of Support staff		267,300	267,300
Mascot man						
15	22-03-2022	COVID-19	Program output 7: Mascot man Cutout		1,550	1,550
56	21-06-2022	COVID-19	Program output 7: Mascot man Cutout		153,450	153,450
Hiring of GPS						
52	26-05-2022	COVID-19	Hiring of GPS Device		22,500	22,500
5	26-05-2022	COVID-19	Hiring of GPS Device		22,500	22,500
Branding of vehicle						
11	26-05-2022	COVID-19	Branding of vehicle (fabrication, fiber, vinyl, Mascot man, decoration)		225,000	225,000
49	26-05-2022	COVID-19	Branding of vehicle (fabrication, fiber, vinyl, Mascot man, decoration)		225,000	225,000
TOTAL					**11,810,000**	**11,810,000**
FACE Form (April - June 2021)						
Act 1.1		Develop campaign strategy, note, theme, key messages for promotion of CAB behaviours and promotion of Covid-19 vaccination				
1.1.1	**Desk Review of available Data**					

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
23	12-06-2021	Activity 1.1.1: Hiring of 2 professionals x 8 days	Advance payment to Dr. Sachin Awasthi and Dr. Vikrant Badge	112,000	10,000	10,000
27	14-06-2021		Advance payment to Dr. Sachin Awasthi and Dr. Vikrant Badge		20,000	20,000
81	18-06-2021		Advance payment to Dr. Sachin Awasthi and Dr. Vikrant Badge		30,000	30,000
82	19-06-2021		Final Payment to Dr. Sachin Awasthi and Dr. Vikrant Badge		52,000	52,000
12	28-06-2021	Activity 1.1.2: Hiring of Vehicles x 5 days	Payment to Jitendra Sharma	22,500	5,000	5,000
114	28-06-2021		Payment to Jitendra Sharma		17,500	17,500
36	15-06-2021	1.1.4: Strategy development including Theme, Mascot, branding, key messages and positioning of key messages Hiring of Professional for development x 10 days	Advance payment made to Navit Dutt/Gulab Kumari	120,000	35,000	35,000
92	22-06-2021		Final Payment made to Navit Dutt and Gulab Kumari based on the invoice received		85,000	85,000
15	09-06-2021	1.2.1 Develop outdoor visibility materials for peer to peer and outdoor communication materials for promotion of CAB behaviours and promotion of vaccine that includes market place, public transportation, govt buildings, common service centers, panchayat bhawans, chemist shop, PDS (Poster, Baners, Booklets, Graphics, Folder and Audio Messages) Development of Posters, Banners, leaflet, handbill and pamphlet Booklets, Folder Hiring of Graphics designer x 15 days	Advance Payment to Ajit Pandey	112,500	25,000	25,000
76	19-06-2021		Final Payment to Ajit Pandey on receipt of Invoice		87,500	87,500
18	10-06-2021	1.2.2: Development of Posters, Banners, leaflet, handbill and pamphlet Booklets, Folder: Hiring of Animator for Motion Poster Design * 15 days	Advance payment to Aman Bhardwaj	120,000	45,000	45,000
74	19-06-2021		Final Payment to Aman Bhardwaj		75,000	75,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
52	15-06-2021	1.2.3: Development of 3 Audio messages of 1-2 minutes for public announcement in Urban Slums and Rural areas on: 1. CAB 2. Covid-19 Vaccination promotion 3. Vaccine Safety Honorarium for Voice over artist x 6 Voice over	Cash Payment to Ashish Dave (Advance)	30,000	5,000	5,000
53	15-06-2021		Cash Payment to Ashish Dave (Advance)		5,000	5,000
54	15-06-2021		Cash Payment to Ashish Dave (Advance)		5,000	5,000
55	15-06-2021		Cash Payment to Ashish Dave (Advance)		5,000	5,000
56	15-06-2021		Cash Payment to Ashish Dave (Advance)		5,000	5,000
57	15-06-2021		Final cash Payment to Ashish Dave		5,000	5,000
13	08-06-2021	Hiring of recording studio for recording and dubbing x 2 days	Advance payment to Chaityanya Bhatt	36,000	15,000	15,000
59	15-06-2021		Final payment to Chaitanya Bhatt		21,000	21,000
14	08-06-2021	Honorarium for Sound Engineer for background music and effects x 3 Audio	Advance payment made to Chaityanya Bhatt	36,000	15,000	15,000
60	15-06-2021	Honorarium for Sound Engineer for background music and effects x 3 Audio	Final Payment to Chaityanya Bhatt		21,000	21,000
64	16-06-2021	1.2.4: Printing of Folders, Flash Cards and Pamphlets Printing cost of Folders 270 GSM	Advance payment to Alok Jain	216,000	50,000	50,000
78	19-06-2021	1.2.4: Printing of Folders, Flash Cards and Pamphlets Printing cost of Folders 270 GSM	Final Payment to Alok Jain		166,000	166,000
25		Printing cost of Flash Cards 340 GSM		288,000		288,000
63		Printing cost of Flash Cards 340 GSM				
26	13-06-2021	Printing cost of Pamphlets 120 GSM	Advance payment to Alok Jain	350,000	100,000	100,000
62	15-06-2021	Printing cost of Pamphlets 120 GSM	Final Payment to Alok Jain		250,000	250,000
61	15-06-2021	Activity 1.3: Printing cost x 18 sqft per Banner	Advance payment to Hemant Sharma	324,000	150,000	150,000
79	19-06-2021	Activity 1.3: Printing cost 18 sqft per Banner	Final Payment to Hemant Sharma		174,000	174,000
28	14-06-2021	Activity 1.3.2: Printing cost x 6 sqft per Poster	Advance payment	1,080,000	400,000	400,000
65	16-06-2021	Printing cost x 6 sqft per Poster	Final payment		680,000	680,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
29	15-06-2021	Activity 2.3: Collaboration with local urban bodies, municipal corporations, and mahila arogrya samitis to integrated communication interventions in ongoing activities Printing cost of Leaflets 270 GSM A4 Size	Advance payment	270,000	90,000	90,000
68	16-06-2021	Printing cost of Leaflets 270 GSM A4 Size	Final payment		180,000	180,000
30	15-06-2021	Printing cost of Handbills 120 GSM	Advance payment	175,000	50,000	50,000
69	16-06-2021	Printing cost of Handbills 120 GSM	Final Payment		125,000	125,000
70	18-06-2021	Activity 2.4: Establish partnership with public relation society of India to document COVID stories, identification of COVID heroes, video bytes of key influencers and organising online competition for university students for PSAs Activity 2.4 Hiring of Camera person		25,000	25,000	25,000
72	18-06-2021	Activity 2.4 Hiring of Lightman		15,000	15,000	15,000
75	19-06-2021	Activity 2.4 Hiring of Sound engineer		20,000	20,000	20,000
71	18-06-2021	Activity 2.4 Hiring of Script writer for messages finalisation		10,000	10,000	10,000
73	18-06-2021	Activity 2.4 Hiring of Studio with Editor		36,000	36,000	36,000
31	15-06-2021	Liaise with caste-based organisations, milk federation and market associations for promotion of CAB behaviours and covid-19 vaccination	Payment to Alok Jain	81,000	20,000	20,000
105	26-06-2021	Activity 2.5: Printing cost x 18 sqft per Banner	Payment to Alok Jain		61,000	61,000
32	15-06-2021	Printing cost x 6 sqft per Poster x 2000 Poster	Payment to Alok Jain	108,000	30,000	30,000
108	26-06-2021	Printing cost x 6 sqft per Poster x 2000 Poster	Final Payment		78,000	78,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
33	15-06-2021	Printing Cost Leaflets 270 GSM A4 Size x 500 Leaflets	Payment to Alok Jain	27,000	10,000	10,000
107	26-06-2021	Printing Cost Leaflets 270 GSM A4 Size x 500 Leaflets	Payment to Alok Jain		17,000	17,000
34	15-06-2021	Activity 2.6: Printing Cost Leaflets 270 GSM A4 Size for religious leaders, leaders of market association x 1000 Leaflets	Payment to Alok Jain	54,000	10,000	10,000
110	27-06-2021	Activity 2.6: Printing Cost Leaflets 270 GSM A4 Size for religious leaders, leaders of market association x 1000 Leaflets	Payment to Alok Jain		44,000	44,000
40	15-06-2021	Activity 2.7: Cost of character designing x 5 characters	Payment to Aman Bhardwaj	50,000	20,000	20,000
93	22-06-2021	Activity 2.7: Cost of character designing x 5 characters	Payment to Aman Bhardwaj		30,000	30,000
41	15-06-2021	Activity 2.7: Cost of environment design x 3 Set	Payment to Aman Bhardwaj	15,000	15,000	15,000
42	15-06-2021	Activity 2.7: Cost of character animation as per script and dialogues x 180 seconds	Payment to Aman Bhardwaj	114,000	40,000	40,000
99	25-06-2021	Activity 2.7: Cost of character animation as per script and dialogues x 180 seconds	Payment to Aman Bhardwaj		73,700	74,000
43	15-06-2021	Activity 2.7: Cost of props animation x 180 seconds	Payment to Aman Bhardwaj	88,000	10,000	10,000
101	25-06-2021	Activity 2.7: Cost of props animation x 180 seconds	Payment to Aman Bhardwaj		77,800	78,000
44	15-06-2021	Activity 2.7: Cost of visual effects x 180 seconds	Payment to Aman Bhardwaj	99,000	20,000	20,000
98	24-06-2021	Activity 2.7: Cost of visual effects x 180 seconds	Payment to Aman Bhardwaj		79,000	79,000
84	19-06-2021	Activity 2.7: Honorarium for Editor x 3 minutes	Payment to Aman Bhardwaj	18,000	18,000	18,000
89	19-06-2021	Activity 2.7: Honorarium for voice over artist x 5-character	Payment to Aman Bhardwaj	25,000	25,000	25,000
91	19-06-2021	Activity 2.7: Honorarium for sound engineer for music and sound effects for video x 3 minutes	Payment to Aman Bhardwaj	15,000	15,000	15,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
77	19-06-2021	Activity 2.7: Honorarium for carry catcher artist for story board x 3 Minutes	Payment to Aman Bhardwaj	18,000	18,000	18,000
83	19-06-2021	Activity 2.7: Printing cost of Flash Cards 340 GSM x 1000 cards	Payment to Hemant Sharma	24,000	24,000	24,000
80	19-06-2021	Printing Cost of Booklets 120 GSM x 1000 booklets	Payment to Hemant Sharma	150,000	50,000	50,000
118	28-06-2021	Printing Cost of Booklets 120 GSM x 1000 booklets	Payment to Hemant Sharma		100,000	100,000
97		Printing of Ready reckoner of Covid Vaccination 270 GSM x 2000	Payment to Hemant Sharma	36,000	36,000	36,000
16	19-06-2021	ACTIVITY 3.1: Develop tailor made digital (Hybrid Format) modules (Approx. Total 12 Minutes) and toolkit and organise training of BMC staff Caste based organisations, Market association representatives, SHGs and volunteers on promotion of CAB, vaccination, home isolation and quarantine, signs and symptoms, use of materials, social mobilisation and IPC and engagement and role Cost of character designing x 12 characters	Payment to Aman Bhardwaj	120,000	40,000	40,000
90	19-06-2021		Payment to Aman Bhardwaj		80,000	80,000
47	19-06-2021	Act 3.1: Cost of environment design x 3 Set	Payment to Aman Bhardwaj	15,000	15,000	15,000
22	12-06-2021	Act 3.1: Cost of character animation as per script and dialogues	Payment to Aman Bhardwaj	457,000	80,000	80,000
94	22-06-2021	Act 3.1: Cost of character animation as per script and dialogues	Payment to Aman Bhardwaj		376,800	377,000
45	15-06-2021	Act 3.1: Cost of props animation	Payment to Aman Bhardwaj	352,000	120,000	120,000
96	24-06-2021	Act 3.1: Cost of props animation	Payment to Aman Bhardwaj		231,200	232,000
39	15-06-2021	Act 3.1: Cost of visual effects	Payment to Nikhil	395,000	100,000	100,000
95	22-06-2021	Act 3.1: Cost of visual effects	Payment to Nikhil		294,000	295,000
48	15-06-2021	Act 3.1: Editing: Honorarium for Editor	Payment to Nikhil	72,000	20,000	20,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
100	25-06-2021	Act 3.1: Editing: Honorarium for Editor	Payment to Nikhil		52,000	52,000
49	15-06-2021	Act 3.1: Voice over: Honorarium for voice over artist	Payment to Ashish Dave	60,000	20,000	20,000
104	25-06-2021	Act 3.1: Voice over: Honorarium for voice over artist	Payment to Ashish Dave		40,000	40,000
67	16-06-2021	Act 3.1: Music and sound effects for video: Honorarium for sound engineer for music and sound effects for video	Payment to Anuj Bhatt	60,000	20,000	20,000
102	25-06-2021	Act 3.1: Music and sound effects for video: Honorarium for sound engineer for music and sound effects for video	Payment to Anuj Bhatt		40,000	40,000
50	15-06-2021	Act 3.1: Composing the sketches: Honorarium for carry catcher artist for story board	Payment to Aman Bhardwaj	72,000	15,000	15,000
103	25-06-2021	Act 3.1: Honorarium for carry catcher artist for story board	Payment to Aman Bhardwaj		57,000	57,000
88	30-06-2021	Program Output 5: Human Resource to manage the project "COVID-19 communication support for vaccine roll out and promotion of CAB behaviours" for 12 months Hiring of 1 State Coordinator: Professional fee	To Shasham Jain	50,000	50,000	50,000
85	30-06-2021	Travel cost for State Coordinator	To Shasham Jain	15,000	15,000	15,000
87	30-06-2021	Hiring of 3 District Coordinator: Professional fee	Ravi Goyal, Shraddha Jadon and Himanshu Malviya	90,000	90,000	90,000
86	30-06-2021	Travel cost for District Coordinator	Ravi Goyal, Shraddha Jadon and Himanshu Malviya	30,000	30,000	30,000
Total				**6,108,000**	**5,817,500**	**6,108,000**
FACE Form (July to November 2021)						
175	28-10-2021	Activity 2.1: Partnerships established to maximise the reach of COVID-19 communication, especially visibility and amplification and promotion of CAB behaviours	Program Output 2; Activity 2.1: Celebration of 100cr vaccination -2 days workshop of artist & painting exhibition		150,000	150,000
179	10-10-2021		Program Output 2; Activity 2.1: Celebration of 100cr vaccination -2 days workshop of artist & painting exhibition		330,000	330,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
121	18-09-2021	Activity 2.2: Roll out multimedia vehicles communication vans in slums, high density population and market places-4 Multimedia van Fully equipped with LED TV (50 inch), audio/video material, PA system, facilitator for interaction, power back up system, support staff with mascot men and GPS tracking device	Programme output 2; Activity 2.2. Hiring of LED TV (50 inch)	Advance	80,000	80,000
130	23-09-2021		Programme output 2; Activity 2.2. Hiring of LED TV (50 inch)	Advance	100,000	100,000
142	27-09-2021		Programme output 2; Activity 2.2. Hiring of LED TV (50 inch)	Final Payment	180,000	180,000
122	18-09-2021		Programme output 2; Activity 2.2, Hiring of PA System	Advance	50,000	50,000
132	23-09-2021		Programme output 2; Activity 2.2, Hiring of PA System	Advance	80,000	80,000
147	28-09-2021		Programme output 2; Activity 2.2, Hiring of PA System	Final Payment	158,000	158,000
125	19-09-2021		Programme output 2; Activity 2.2, Hiring of Portable Generator to run TV and PA System	Advance	100,000	100,000
134	23-09-2021		Programme output 2; Activity 2.2, Hiring of Portable Generator to run TV and PA System	Advance	200,000	200,000
151	29-09-2021		Programme output 2; Activity 2.2, Hiring of Portable Generator to run TV and PA System	Final Payment	300,000	300,000
126	20-09-2021		Programme output 2; Activity 2.2, GPS Device	Advance	9,000	9,000
138	26-09-2021		Programme output 2; Activity 2.2, GPS Device	Final Payment	9,000	9,000
119	17-09-2021		Programme output 2, Activity 2.2, Branding of Vehicle that includes (Fabrication flex, vinyl, mascot man cutouts and decoration)	Advance	50,000	50,000
123	19-09-2021		Programme output 2, Activity 2.2, Branding of Vehicle that includes (Fabrication flex, vinyl, mascot man cutouts and decoration)	Final Payment	130,000	130,000
120	17-09-2021		Programme output 2, Activity 2.2, Hiring of Vehicle (Pick up/Bolero) with driver	Advance	50,000	50,000
137	25-09-2021		Programme output 2, Activity 2.2, Hiring of Vehicle (Pick up/Bolero) with driver	Advance	200,000	200,000
155	30-09-2021		Programme output 2, Activity 2.2, Hiring of Vehicle (Pick up/Bolero) with driver	Final Payment	302,000	302,000
124	19-09-2021		Programme output 2, Activity 2.2, POL for vehicles	Advance (Cash)	200,000	200,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
131	23-09-2021		Programme output 2, Activity 2.2, POL for vehicles	Advance (Cash)	200,000	200,000
149	29-09-2021		Programme output 2, Activity 2.2, POL for vehicles	Final Payment (Cash)	200,000	200,000
135	25-09-2021		Programme output 2, Activity 2.2, Hiring of Facilitator		45,000	45,000
143	27-09-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
158	25-09-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
160	25-09-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
161	25-10-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
162	25-10-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
164	25-10-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
166	25-10-2021		Program output 2, Activity 2.2, Hiring of facilitator for		45,000	45,000
159	25-09-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
165	25-10-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
167	25-10-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
169	25-10-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
171	25-10-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
163	25-09-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
145	27-09-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
136	24-09-2021		Programme Output 2, Activity 2.2, Hiring of Supporting Staff		27,000	27,000
128	21-09-2021		Programme output 2, Activity 2.2, Mascot man cutout	Final Payment	54,000	54,000
178	24-10-2021	Activity 2.4: Establish partnership with public relation society of India to document COVID stories, identification of COVID heroes, video bytes of key influencers and organising online competition for	Programme output 2, Activity 2.4, Orientation of Litterateur/Writers Honorarium for resource person		10,000	10,000
184	30-10-2021		Programme output 2, Activity 2.4, Orientation of Litterateur/Writers		10,000	10,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
		university students for PSAs	Honorarium for resource person			
185	24-10-2021		Programme output 2, Activity 2.4, Orientation of Litterateur/Writers packing of the messages and material to be given to litterateur/writer in a pen drive	Pen drive cost Rs. 650*30 pen drive	19,500	19,500
131A	30-07-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator, professional fees		50,000	50,000
133A	30-08-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator, professional fees		50,000	50,000
135A	30-09-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator, professional fees		50,000	50,000
137A	30-10-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator, professional fees		50,000	50,000
148A	30-11-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator, professional fees		50,000	50,000
119A	30-07-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator travel cost		15,000	15,000
122A	30-08-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator travel cost		15,000	15,000
125A	30-09-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator travel cost		15,000	15,000
127A	30-10-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator travel cost		15,000	15,000
146A	30-11-2021	Activity 5.1 Hiring of 1 State Coordinator	Programme output 5, Hiring of 1 State Co-ordinator travel cost		15,000	15,000
128A	30-07-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 District Coordinator		90,000	90,000
130A	30-08-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 District Coordinator		90,000	90,000
132A	30-09-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 District Coordinator		90,000	90,000
134A	30-10-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 District Coordinator		90,000	90,000
150A	30-11-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 District Coordinator		90,000	90,000
120A	30-07-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 DC Travel Cost		30,000	30,000
121A	30-08-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 DC Travel Cost		30,000	30,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
123A	30-09-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 DC Travel Cost		30,000	30,000
124A	30-10-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 DC Travel Cost		30,000	30,000
157A	30-11-2021	Activity 5.2: Hiring of District Coordinator	Programme output 5, Hiring of 3 DC Travel Cost		30,000	30,000
Total					**4,672,500**	**4,672,500**
FACE FORM (Feb to March 2022)						
Activity 2.6						
401	29-03-2022	Organisation of content development workshop	Payment to Soch Films and Publication		160,000	160,000
437	31-03-2022		Payment to Soch Films and Publication		200,000	200,000
410	29-03-2022	Purchase of stationery	Cash Payment to Soch Films		10,250	10,250
415	14-03-2022	Honorarium of resources person	Payment to Soch Films and Publication		30,000	30,000
440	16-03-2022	Hiring of Troupes for 45 days for 2 districts	Payment to Soch Films and Publication		340,000	340,000
420	16-03-2022		Payment to Soch Films and Publication		200,000	200,000
Activity 4.2						
549	02-03-2022	Boarding and lodging for 40 Participants @twin sharing;	Payment to Soch Films and Publication		50,000	50,000
592	02-03-2022	Boarding and lodging for 40 Participants @twin sharing;	Payment to Soch Films and Publication		142,000	142,000
550	02-03-2022	Breakfast, lunch, dinner and tea snacks for 45 participants	Payment to Soch Films and Publication		50,000	50,000
570	02-03-2022	Breakfast, lunch, dinner and tea snacks for 45 participants	Payment to Soch Films and Publication		85,000	85,000
552	02-03-2022	Honorarium for the 40 Participants	Payment to Soch Films and Publication		50,000	50,000
580	02-03-2022	Honorarium for the 40 Participants	Payment to Soch Films and Publication		150,000	150,000
562	02-03-2022	Honorarium of resource person (3) for workshop	Payment to Soch Films and Publication		10,000	10,000
576	02-03-2022	Honorarium of resource person (3) for workshop	Payment to Soch Films and Publication		20,000	20,000
545	02-03-2022	Stationery and miscellaneous purchase	Cash Payment to Soch Films and Publication		10,000	10,000
Activity 4.3						
357	02-02-2022	Hiring of Camera person	Cash Payment to Soch Films and Publication		10,000	10,000
402	02-03-2022	Hiring of Camera person	Payment to Soch Films and Publication		70,000	70,000
358	20-02-2022	Hiring of 2 light man	Cash Payment to Soch Films and Publication		6,000	6,000
405	02-03-2022	Hiring of 2 light man	Payment to Soch Films and Publication		42,000	42,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
362	02-02-2022	Hiring of Sound recordist	Payment to Soch Films and Publication		12,000	12,000
409	02-03-2022	Hiring of Sound recordist	Payment to Soch Films and Publication		36,000	36,000
365	02-03-2022	Hiring of Camera light reflector and other equipment	Payment to Soch Films and Publication		60,000	60,000
413	02-03-2022	Hiring of Camera light reflector and other equipment	Payment to Soch Films and Publication		52,000	52,000
367	02-02-2022	Hiring of two Assistants	Payment to Soch Films and Publication		15,000	15,000
417	02-03-2022	Hiring of two Assistants	Payment to Soch Films and Publication		30,000	30,000
371	02-03-2022	Voice over ,2 sound recording studio charges;	Payment to Soch Films and Publication		30,000	30,000
421	02-03-2022	Voice over ,2 sound recording studio charges;	Payment to Soch Films and Publication		82,000	82,000
376	02-02-2022	Music and sound effects of the film	Cash Payment to Soch Films and Publication		10,000	10,000
436	02-02-2022	Music and sound effects of the film	Cash Payment to Soch Films and Publication		10,000	10,000
378	02-02-2022	Editing of the film	Cash Payment to Soch Films and Publication		20,000	20,000
441	02-03-2022	Editing of the film	Payment to Soch Films and Publication		77,500	77,500
379	02-03-2022	Travel cost	Payment to Soch Films and Publication		15,000	15,000
445	02-03-2022	Travel cost	Payment to Soch Films and Publication		34,500	34,500
380	02-02-2022	Script writing	Cash Payment to Soch Films and Publication		10,000	10,000
447	02-02-2022	Script writing	Cash Payment to Soch Films and Publication		10,000	10,000
Activity 4.4						
342	01-03-2022	Report Documentation hiring expert	Payment to Anand Panjiyar		20,000	20,000
410	16-03-2022	Report Documentation hiring expert	Payment to Anand Panjiyar		40,000	40,000
343	01-03-2022	Report documentation (Field visit travel cost)	Payment to Anand Panjiyar		10,000	10,000
411	16-03-2022	Report documentation (Field visit travel cost)	Payment to Anand Panjiyar		17,000	17,000
344	05-03-2022	Report designing	Cash payment to Anand Panjiyar		16,000	16,000
412	18-03-2022	Report designing	Cash payment to Anand Panjiyar		14,000	14,000
Program output 5						
448	28-02-2022	Hiring of 1 State Coordinator Professional fee	Payment to Shasham Jain		50,000	50,000
560	29-03-2022	Hiring of 1 State Coordinator Professional fee	Payment to Shasham Jain		50,000	50,000
449	29-02-2022	Travel cost to State coordinator	Payment to Shasham Jain		15,000	15,000
578	29-03-2022	Travel cost to State coordinator	Payment to Shasham Jain		15,000	15,000
500	28-02-2022	Professional fee to 2 District Coordinators	Ravi Goyal, Shraddha Jadon		60,000	60,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
501	28-02-2022	Professional fee to 1 District Coordinator	Himanshu Malviya		30,000	30,000
502	28-03-2022	Professional fee to 2 District Coordinators	Ravi Goyal, Shraddha Jadon		60,000	60,000
585	29-03-2022	Professional fee to 1 District Coordinator	Himanshu Malviya		30,000	30,000
503	29-02-2022	Travel cost to District coordinators	Ravi Goyal, Shraddha Jadon		20,000	20,000
504	28-03-2022	Travel cost to 1 District coordinator	Himanshu Malviya		10,000	10,000
505	29-03-2022	Travel cost to District coordinators	Cash payment to Ravi Goyal, Shraddha Jadon		20,000	20,000
595	29-03-2022	Travel cost to 1 District coordinator	Cash Payment to Himanshu Malviya		10,000	10,000
Activity 6.1.2						
323	14-03-2022	Creation of content for knowledge enhancement audio package. Hiring Music composer, Honorarium of Sund engineer for Background Music and effects,	Advance Payment to Soch Films		100,000	100,000
390	16-03-2022	Creation of content for knowledge enhancement audio package. Hiring Music composer, Honorarium of Sund engineer for Background Music and effects,	Final payment to Soch Films		500,000	500,000
322	14-03-2022	Hiring of Artist (Honorarium for 5 voice over artist)	Advance to Soch Films		50,000	50,000
389	16-03-2022	Hiring of Artist (Honorarium for 5 voice over artist)	Final payment to Soch Films		75,000	75,000
324	14-03-2022	Hiring of recording studio for recording	Cash Payment to Soch Films		10,000	10,000
363	15-03-2022	Hiring of recording studio for recording	Payment to Soch Films		62,000	62,000
325	14-03-2022	Editing of Audit content (Honorarium for editors)	Advance Payment to Soch Films		50,000	50,000
345	14-03-2022	Editing of Audit content (Honorarium for editors)	Payment to Soch Films		70,000	70,000
326	14-03-2022	Creation of 3 Songs including lyrics writing, composing, singling and recording	Advance payment to Soch Films		100,000	100,000
382	16-03-2022	Creation of 3 Songs including lyrics writing, composing, singling and recording	Advance payment to Soch Films		100,000	100,000
383	20-03-2022	Creation of 3 Songs including lyrics writing, composing, singling and recording	Final Payment to Soch Films		400,000	400,000
555	24-03-2022	Honorarium to consultants	Payment to Soch Films		50,000	50,000

Voucher n°	Voucher Date	Grant	Transaction description	FACE FORM amount	Amount in voucher	Irregular
589	20-03-2022	Printing cost of manual	Cash Payment to Soch Films for printing facilitators manual		6,000	6,000
598	24-03-2022	Honorarium to consultants	Payment to Soch Films (Develop user's manual (How to use KEAP and Initiate small meetings, FGDs etc.)		50,000	50,000
563	18-03-2022	Printing cost of manuals	Payment to Soch Films		129,000	129,000
548	10-03-2022	Honorarium to resource person	Cash payment to soch films		20,000	20,000
575	21-03-2022	TOT for Master trainers (f2f training for 2 days)	Advance Payment to Soch Films		200,000	200,000
542	18-03-2022	Hiring of 2 professionals	Payment to Soch films		100,000	100,000
572	19-03-2022	Travel cost for evaluation of 2 districts	Cash Payment to Soch films		16,000	16,000
Total					**4,714,250**	**4,714,250**
Grand Total					**27,014,250**	**27,304,750**
Gavi Contribution – 75.382%						**20,582,867**

Voluntary Health Association of India

Voucher n°	Voucher Date	Grant	Transaction description	Amount in voucher	Inadequate	Ineligible
524	28-Aug-24	Activity 1.12.1	Refreshment to assessment team conducting Micro Assessment(snacks)	60		60
525	28-Aug-24	Activity 1.12.1	Refreshment to assessment team conducting Micro Assessment (Lunch)	754		754
541	30-Aug-24	Activity 1.12.1	Payment for repairing of Laptops (3)-Laptop upgradation	9,558		1,458
542	30-Aug-24	Activity 1.12.1	Payment for repairing of Laptops (3)-Laptop upgradation	13,216		2,016
552	31-Aug-24	Activity 1.12.1	Payment for repairing of Laptops (1)-Laptop upgradation	6,844		1,044
553	31-Aug-24	Activity 1.12.1	Payment for Printer repair (glass change) to Nimbus one IT services.	7,257		1,107
589	9-Sep-24	Activity 1.12.1	Payment for laptop repair of DC to Nimbus one IT Service.	6,844		1,044
591	10-Sep-24	Activity 1.12.1	Payment for projector Lamp replacement to NimbusoneIT Service.	10,384		1,584
603	10-Sep-24	Activity 1.12.1	Payment to Kinjal Designs for printing of Brochure	9,744		1,044
24	30-Sep-24	Activity 1.12.1	Salary of National Office staff for the period of Jul-24 to Sep-24.	75,537		75,537
532	30-Aug-24	Activity 1.12.2	Courier charges for sending Laptops to AP office	6,419		980
652	17-Sep-24	Activity 1.12.2	Travel reimbursement to Swapnil Jain for visit to AP for meeting with UNICEF & other health department officials	43,590		1,440
670	24-Sep-24	Activity 1.8	Paid to GAN International for courier of stationery items for project staff for mapping exercise & other field activities at Arunachal Pradesh.	17,552	17,552	-
671	24-Sep-24	Activity 1.8	Paid to GAN International for Courier charges for Bags, stationery items, brochures & other field activities at Arunachal Pradesh.	17,553	17,553	-

Voucher n°	Voucher Date	Grant	Transaction description	Amount in voucher	Inadequate	Ineligible
733	30-Sep-24	Activity 2.1	Purchase of 40 bags for UNICEF Meeting for convergence meeting at Naharlagun	58,000		8,843
24	30-Sep-24	Activity 2.12.1	Salary of National Office staff has been booked for the period of Jul-24 to Sep-24.	323,012		323,012
302	2-Jul-24	Activity 3.2.1	Repairing of Swapnil's Laptop (Payment made to Nimbus one IT Services)	4,189		639
401	25-Jul-24	Activity 3.2.1	-Zoom subscription charges (One year validity- July 6 2024 to July 5 2025) for 1 user (invites up to 100 participants) amounting to 15,381 -Job posting charges (DevNetJobsIndia.org) amounting to 7965 and 2655- State coordinator, State M&E, District Coordinator and Block Coordinators	23,346		15,381
457	6-Aug-24	Activity 3.2.1	Payment for the Compatible Toner (78A) TO Nimbus one IT Services Pvt. Ltd.	1,200		183
503	22-Aug-24	Activity 3.2.1	Payment to Shivam Traders for purchase of stationery items.	3,050		417
581	5-Sep-24	Activity 3.2.1	Payment to Abhishek Enterprises for Visiting cards prints. Paid to Abhishek enterprises for printing of visiting cards of Phalguni Chaturvedi, Hemanta Borah & Moyaseng Manwai	944		144
903	21-Oct-24	Activity 1.12.1	Paid to hotel Golden Orchid for organising orientation and planning workshop & induction meeting along with accommodation of DCs, BCs & DIOs from 15.10.2024 to 19.10.2024	274,488		52,224
913	28-Oct-24	Activity 1.12.1	Payment for Diwali gifts -28 October 2024 to 46 staff for F.Y. 2024-25	18,000		18,000
1124	19-Dec-24	Activity 1.2	Paid to Hotel Golden Orchid for arranging hall, lunch, tea etc for meeting & accommodation of participants from 09.12.2024 to 11.12.2024.	39,690		1,890
1124	19-Dec-24	Activity 1.3	Paid to Hotel Golden Orchid for arranging hall, lunch, tea etc for meeting & accommodation of participants from 09.12.2024 to 11.12.2024.	524,614		33,408
848	10-Oct-24	Activity 2.1	Paid to GAN International for courier charges for sending bags & kit material for orientation & planning workshop to naharlagun against	17,051	14,451	2,600
913	28-Oct-24	Activity 2.12.1	Diwali gift	45,000		45,000
940	30-Oct-24	Activity 2.12.1	Paid to Kinjal Designs for banner printing of UNICEF orientation and planning workshop & induction meeting against invoice no. 201.	1,694		378
958	5-Nov-24	Activity 2.12.1	Paid to Kinjal Designs for printing of UNICEF project brochures against invoice no. 187.	168,000	168,000	-
1023	28-Nov-24	Activity 2.12.1	Paid to Kinjal Designs for printing of IEC materials for UNICEF project against invoice no. 224.	87,091		9,331
1061	4-Dec-24	Activity 2.12.1	Paid to Satyaa Enterprises for courier to VHAI Arunachal Pradesh office material related to UNICEF project for staff	25,677		3,917
78	31-Dec-24	Activity 2.12.1	Salary of National Office staff for the period of Dec-24.	52,637		52,637
1193	7-Jan-25	Activity 2.12.1	Paid to Nimbus one IT Services Pvt. Ltd for purchase of toner for sushil's printer	1,200		183
69	30-Nov-24	Activity 2.13.1	Salary of National Office staff for the period of Oct-24 & Nov-24.	205,222		205,222
1088	17-Dec-24	Activity 2.13.1	Paid to Inspired Engineering solutions for photocopy charges for the month of Nov-24.	4,720		900
1191	7-Jan-25	Activity 2.13.1	Paid to Inspired Engineering Solutions for photocopy charges for the month of Dec-24.	3,540		900

Voucher n°	Voucher Date	Grant	Transaction description	Amount in voucher	Inadequate	Ineligible
1150	31-Dec-24	Activity 2.5	Paid to Kinjal Designs for printing of badges for UNICEF project & dairies for state officials under UNICEF project.	51,072		6,516
887	21-Oct-24	Activity 3.2.1	Paid to Inspired Engineering Solutions for photocopy charges for the month of Sept-24.	2,950		900
913	28-Oct-24	Activity 3.2.1	Paid to UNICEF project staff as Diwali gift for the F.Y. 2024-25.	11,000		11,000
Total				**2,172,699**	**217,556**	**881,693**

Envisions Institute of Development

Voucher n°	Voucher Date	Grant	Transaction description	Amount in voucher	Inadequate	Ineligible
JV 26	4/22/2024	Input Level Budget 1.11: INAP: PF for two team members viz project leader, and senior resource person for 9 days each	Professional fees to Nisar Ahmad	90,000	90,000	-
JV 29	4/22/2024		Professional fees to Varsha Chanda	90,000	90,000	-
JV 27	4/22/2024		Professional fees to Nisar Ahmad	50,000	50,000	-
JV 30	4/22/2024		Professional fees to Varsha Chanda	50,000	50,000	-
JV 28	4/22/2024	Input Level Budget 1.21: RI: PF for two team members viz project leader, and senior resource person for 6 days each	Professional fees to Nisar Ahmad	60,000	60,000	-
JV 33	4/22/2024		Professional fees to Varsha Chanda	60,000	60,000	-
JV-253	12/2/2023		Payment to Rajendar (office help cum driver)	2,500	2,500	-
JV-292	1/3/2024		Payment to Rajendar (office help cum driver)	2,500	2,500	-
JV-324	2/5/2024		Payment to Rajendar (office help cum driver)	2,500	2,500	-
JV-355	3/4/2024		Payment to Rajendar (office help cum driver)	2,500	2,500	-
JV-008	4/2/2024		Payment to Rajendar (office help cum driver)	2,500	2,500	-
JV-046	5/20/2024		Payment to Rajendar (office help cum driver)	2,500	2,500	-
JV-182	8/22/2024	Input Level Budget 2.11: PF for development of concept note & agenda (2 day), coordination with CSO/NGO (2 day) and facilitation of 2-day state level workshop on SBC (4 day) for key line department.	Professional fees to Sunita Bhane (CSO SBC Training in the month of July for 3 days)	15,000	15,000	-
JV-183	8/22/2024		Professional fees to Mazhar Khan (CSO SBC Training- 3 days in the month of July)	10,500	10,500	-
JV-195	9/2/2024		Professional fees to Varsha Chanda	29,500	29,500	-
JV-212	9/2/2024		Payment to Nishar Ahmad for CSO SBC Training (2.5 days)	25,000	25,000	-
JV-074	6/22/2024	Input Level Budget 2.14: 1 Workshop logistics for 20 outstation participants residential: B&L x 20x2 day	Payment to YMCA	300,000	-	51,403
JV-110	7/30/2024	Input Level Budget 2.16: 1 Workshop logistics: Travel for 20 outstation participants: Travel 20 @ 7500 (To be reimbursed on actuals)	Workshop Travel reimbursement (Train and Taxi)	6,020	1,200	-
JV-111	7/30/2024		Workshop Travel reimbursement (Cab) (Travelers are Mr. Mahesh Kodgire, Ashwinin, Kotasthane, Abhijeet Kakade)	5,500	5,500	-
JV-112	7/30/2024		Workshop Travel reimbursement (Bus, car)	2,100	1,050	-
JV-115	8/3/2024	Input Level Budget 2.21: PF for Development and standard operating procedures for SBC network (2 days), Network SOP and Setting-up (4 days),	Payment to Eisha (Project Support)	30,000	30,000	-
JV-117	8/3/2024		Professional fees to Mazhar Khan (CSO SBC Project review 27 days)	35,000	35,000	-

Voucher n°	Voucher Date	Grant	Transaction description	Amount in voucher	Inadequate	Ineligible
JV-196	9/2/2024	Coordination and administration (6 days). HR costs 2+4+6 professional days @ 11000	Professional Fees to Mazhar Khan (CSO SBC Project review - 27 days)	31,500	31,500	-
JV-200	9/2/2024		Payment to Eisha	30,000	30,000	-
TOTAL				**935,120**	**629,250** **538,571**	**51,403** **43,995**
		Gavi contribution – 85.58%				

CACR

Voucher n°	Voucher Date	Grant	Transaction description	Amount	Inadequate	Irregular	Ineligible
63 102	31-07-2024 31-08-2024	GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Kalpesh Sudhakar Jadhav	35,000	35,000		
62 125 100	31-07-2024 30-09-2024 31-08-2024	GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Farida Nabi Sayyed	94,500	94,500		
101 79 126	31-08-2024 07-08-2024 30-09-2024	GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Sachin Kailas Dagadhate	84,000	84,000		
98 127	31-08-2024 30-09-2024	GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Aafrin Mohd Atique Shaikh	41,545	41,545		
128	9/30/2024	GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Sayyed Mohd Qasim Mohd Asad	14,000	14,000		
73, 103, 130		GAVI UNICEF HSS3	Documentation & Reporting Officer for GAVI - Professional Fees Jerpula Pavan Kumar	200,000	200,000		
80	8/24/2024	GAVI UNICEF HSS3	Capacity Building of Identified community structures such as CBOs/ULBs/SHGs/MAS - YMCA Programme Center	217,428	217,428		
67, 83, 41, 132		GAVI UNICEF HSS3	Program Head & Review Meetings - Car Hire - Kalyani Roadways	20,755	20,755		
81, 95		GAVI UNICEF HSS3	Operational Costs - Furniture	28,000			28,000
140, 155, 170		GAVI UNICEF HSS3	Documentation & Reporting Officer for GAVI - Professional Fees Jerpula Pavan Kumar	240,000	240,000		
146, 148, 157, 164		GAVI UNICEF HSS3	Program Head & Review Meetings - Car hire - Kalyani Roadways	21,888	21,888		
138, 149, 166		GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Farida Nabi Sayyed	105,000	105,000		
139, 151, 169		GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Sayyed Mohd Qasim Mohd Asad	84,000	84,000		

Voucher n°	Voucher Date	Grant	Transaction description	Amount	Inadequate	Irregular	Ineligible
150, 167		GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Kasif Momin	56,000	56,000		
168		GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Professional fees - Asrar babu Shaikh	25,290	25,290		
138, 149, 166		GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Reimbursement - Farida Nabi Sayyed	28,111		28,111	
139, 151, 150, 169, 167, 168		GAVI UNICEF HSS3	Human Resource Cost for Corporation and UPHC Level - Bhiwandi Nizampur Municipal Corporation - Reimbursements for local conveyances - Sayyed, Kasif & Asrar	28,300		28,300	
141		GAVI UNICEF HSS3	Capacity Building of Identified community structures such as CBOs/ULBs/SHGs/MAS -	68,665	68,665		
133		GAVI UNICEF HSS3	Operational Costs - Furniture	18,172			18,172
TOTAL				**1,410,654**	**1,308,071**	**56,411**	**46,172**

Project Concern International

Voucher n°	Voucher Date	Transaction description	Amount	Ineligible
10574	10/31/2024	Security Services	48,069	48,069
10575	10/31/2024	Repair & Maintenance - Others	25,000	25,000
10576	10/31/2024	Other Consultancies	35,817	35,817
10613	10/31/2024	Repair & Maintenance - Building	25,851	25,851
10823	11/20/2024	Office Rent	50,000	50,000
11841	12/26/2024	Office Rent	50,002	50,002
Total			**234,739**	**234,739**

IIT Bombay

Voucher n°	Voucher Date	Grant	Transaction description	Amount	Inadequate
2426001616	6/6/2024	UNICEF	Human Resources	1,149,900	1,149,900
2440003831	7/30/2024	UNICEF	Cloud Hosting	51,184	51,184
2426009071	12/2/2024	UNICEF	Human Resources	1,147,440	1,147,440
2306013743	3/15/2024	UNICEF	Human Resources	733,234	733,234
2440000327	4/27/2024	UNICEF	Cloud Hosting	9,859	9,859
2440000327, 2417002147	4/27/2024	UNICEF	Consumables	79,464	79,464
2317041625	2/27/2024	UNICEF	Travel	6,315	6,315
2417002005	5/16/2024	UNICEF	Contingency	23,506	23,506
149346, 151775, 154015	31.07.24, 30.08.24, 1.10.24	UNICEF	Human Resources	1,144,965	1,144,965
TOTAL				**4,345,867**	**4,345,867**

Aravali

Voucher n°	Voucher Date	Transaction description	Amount	Ineligible
145	8-Aug-22	payment to Sarita Maurya	25,000	25,000

Voucher n°	Voucher Date	Transaction description	Amount	Ineligible
TOTAL			**25,000**	**25,000**

Dean and Principle SLN Medical College

Voucher n°	Voucher Date	Particulars	Transaction description	Amount	Inadequate
495	2/9/2022	Regional Research Center - Child Health & Nutrition (RCC-CH&N)	Salary to RRC Staff	588,400	24,800
504	3/2/2022	RCC- CH&N	Salary to RRC Staff	588,400	24,800
651	8/6/2022	RCC- CH&N	Salary to RRC Staff	867,800	29,800
685	9/2/2022	RCC- CH&N	Salary to RRC Staff	867,800	29,800
TOTAL				**2,912,400**	**109,200**

Annex 11: Status of management actions from the 2023 Programme Audit

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
eVIN system sustainability challenges must be addressed	**Recommendation 1** To address the sustainability challenges identified UIP should: • Request and review a comprehensive quantification of all fixed and recurring operational costs for eVIN maintenance and ensure all costs are included for national and state level planning. • Ensure that a comprehensive transition plan detailing all associated costs required to operate and maintain eVIN at state and national level is developed; and • Ensure that the plan is used as resource mobilisation tool with the MoHFW to ensure eVIN operational costs are budgeted for and fully financed.	**Action 1** • MoHFW has initiated the transition of eVIN cost at State and district levels since 2018 for HSS I States and subsequently for HSS II States demarcating clearly the eVIN HR and operational costs under state PIPs and for 2023-24, all states and UTs have also proposed the same under state PIPs. • Hosting cost for eVIN for year 2023 (with a no cost extension till June 2024) has now been budgeted and approved under CDS-3 proposal by GAVI and recurring cost is shared by UNDP with MoHFW for post December 2024 by UNDP. Later, it will be incorporated under the domestic budget at national level as per the details shared by UNDP.	MoHFW	31 December 2024	Completed
	Recommendation 2 To address gaps identified in policies, UIP should liaise with UNDP to ensure that the following mitigating actions are taken prior to handover of eVIN to UIP: • Develop a policy to manage data governance, master data management, and change management. This will be critical as eVIN management is transitioned to the UIP; • Revise the current data back policy documentation to include a schedule for restoration testing of backups including frequency of restoration tests, responsible parties for both test management, reporting and quality assurance of successful tests completed; • Include a system protocol/permission that does not accept stock adjustments without required approvals. This protocol should be in place for all system users in eVIN. Super users should also include approvals before adjustments are made to maintain the integrity of data; and • Define the minimum vaccine stock data transactions required from the eVIN database together with UIP. These definitions should be used to determine future transaction back-ups and data required from previous vendor.	**Action 2** As part of overall eVIN management policy, the following will be taken up in consultation with UNDP. • Master Data Management (MDM) - eVIN master data comprises of vaccines master data, locations master data (state /districts/blocks), stores master data, users master data, users master data and assets master data (cold chain equipment and temperature loggers. The MDM will be achieved by: o Cleansing and Correction of Erroneous Data o Regular Data Quality Monitoring and Reporting. o Deduplication, Matching and Unique Keying. o Use of relevant MDM software tool o Easily Integrates and Coexists with other health systems using Local government directory (LGD) code for mapping of location at each level. As of now verification of LGD code is done at state and district level. Unique Code for Land/Region will enable Interoperability. eVIN Cert-in Security and safety • Audit is scheduled in September 2023. Post Audit recommendations, uniform messages to developer and users will be shared for cleansing and correction of erroneous data, regular data quality monitoring and reporting.	MoHFW	31 December 2024	Completed

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
		• Current Policy for Backup Services: UNDP applications require backups should follow the 3-2-1 rule and be maintained at both off-site and on-site locations in secure fireproof and environmentally controlled environments so that the backup media are not harmed. If the offsite is in a different seismic zone from the primary data centre, then S3 in Disaster recovery site can be used instead of offsite backup. o Ensure database backup (full volume and incremental) with a latency of maximum 1 day. This means that at any point of time maximum data loss would be of the last 1-day data. o to avoid performance degradation of the system, such backup should be scheduled out of working hours daily. o Apart from backing up data at the server room, backups should be taken on external media as per the following schedule: o Backup type - Incremental, Frequency-Daily, Storage type- 1 week o Backup type - Incremental, Frequency-weekly, Storage type- 1 month o Backup type – Full Backup, Frequency-monthly, Storage type- 2 months o Service Provider will be responsible for coordinating the retrieval of off-site media in the event of any disaster recovery. o For audit purpose service provider will maintain logs of backup/ restoration • Proposed Additions to the current policy for backup services will include the following Backup restoration Plan: o Restoration Testing Mechanism o Frequency of Restoration Testing- once in 6 months o Responsibility of Restoration Testing and reporting- Technical partners o (Development partner as well as hosting provider) o Quality Assurance of Restoration Testing- UNDP (through data analysis) The Data back-up policy documentation to be shared further with E-Health, MoHFW division for endorsement.			

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
		• Data Governance- We will have robust data governance mechanism by defining roles for managing data, defining data access policies and processes for data security. eVIN root account of hosting platform will be a child account of CoWIN parent account where complete ownership of data by Ministry of Health will be well defined. Data governance policy will be documented covering the following: o Ensure integrity and usability of data. o Standardise data definitions, rules, and descriptions. o Define access policies and optimise data-related workflows and communication. o Data access and storage o Data Security o Data Privacy • Change Management- Version control and code deployment will be done through Continuous Integration / Continuous Delivery (CI/CD) feature on GitHub or relevant feature of AWS Code Commit. Currently whenever a user performs stock edit/adjustment, he/she has to input a valid reason for the same. The programme managers at higher levels can extract the report of such adjustments reason wise from eVIN. Subsequently the user with high number of adjustments is identified and the stocks are reviewed at the DTFI/STFI. As far as approvals for the stock adjustments are concerned, a policy level decision will be taken up at the UIP level. • The number of transactions depend on the programmatic aspects. Routinely only RI vaccines transactions are being done for the UIP sessions, but the transactions keep increasing during the Special immunisation weeks, Mission Indradhanush, IMI, Covid vaccination. The back up of all the transactions is being done on eVIN and at the end of the month, the transactions can be exported from the national level.			
	Recommendation 3 To address gaps identified with project management capacity, the UIP should liaise with UNDP to consider obtaining a suitably qualified in-house resource to oversee the various IT investments including eVIN, U-WIN, CoWIN and NCCMIS. Core competencies in design and implementation of digital systems,	**Action 3** • Technical documentation is ready for eVIN for the knowledge transfer aspect. Under GAVI - HSS-3 proposal, PMU is budgeted which includes IT team with expert in cloud infrastructure, database management who can	MoHFW	31 December 2024	Completed

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
	database management, security and compliance should be obtained to oversee implementation of software development processes and ensure quality, security and availability of data assets.	work on smooth eVIN oversight, infrastructure management and knowledge transfer.			
Security exposures in the National Cold Chain Management Information System need to be addressed	**Recommendation 4** NCCVMRC should procure and setup Secure Socket Layer (SSL) certificate for the NCCMIS domain to ensure web traffic for the application is encrypted.	**Action 4** SSL certificate is now implemented in the NCCMIS website.	MoHFW with NCCVMRC	31 December 2024	Completed
	Recommendation 5 The UIP should commission a comprehensive security audit of the NCCMIS mobile, web and database application.	**Action 5** The security audit for the current year is under process and commenced on 1 April 2023. The audit report is expected by 31 October 2023 and necessary actions will be taken accordingly.			Completed
	Recommendation 6 NCCVMRC should implement audit trail for user actions and encrypt all passwords stored on the NCCMIS database.	**Action 6** The audit trail for NCCMIS was implemented in year 2016 and all the passwords are encrypted as of March 2016. NCCMIS data is hosted on the govt. server (RailTel). All the mentioned requirement is already taken care by the Govt. Service provider. **Audit note:** At the time of the audit, audit trail within NCCMIS was not evident. NCCVMRC is encouraged to implement audit trail within NCCMIS and report on the status of implementation to the IAG on annually.			Completed
	Recommendation 7 NCCVMRC should ensure that all modules are utilised and with support from UIP should engage states to ensure that missing data is input into the system.	**Action 7** MoHFW is currently reviewing the NCCMIS and eVIN systems. The review is aimed at assessing possibilities for: • Integration of some modules of NCCMIS into eVIN • Instituting policies to manage data governance, master data management and change management for NCCMIS. • Including a schedule for restoration testing of backups as part of the data backup policy including frequency of restoration tests and responsible parties for both test management, reporting and QA of successful tests completed for NCCMIS			Ongoing. New Deadline 31 December 2025
	Recommendation 8 NCCVMRC should Institute policies in place to manage data governance, master data management, and change management and include a schedule for restoration testing of backups as part of the data backup policy including frequency of restoration tests and responsible parties for both test management, reporting and QA of successful tests completed.				Ongoing. New Deadline 31 December 2025
The various immunisation and logistics systems need to be integrated	**Recommendation 9** The MoHFW should consider establishing a process to integrate its systems containing vaccine and logistics data, by establishing a singular data warehouse to improve visibility and reduce cases of duplication of data points.	**Action 9** As noted in Action 7 above, the process of integration of some modules of NCCMIS with eVIN is currently under process. MoHFW has conducted consultative meetings with UNDP and NCCVMRC in this regard.	MoHFW	31 December 2024	Ongoing. New Deadline 31 December 2025

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
Physical and human resource capacities at the GMSDs need improvement	**Recommendation 10** The UIP should work with the Directorate of Health Services to ensure that an appropriate level of staffs are deployed at the GMSDs	**Action 10** MoHFW is in discussion with DGHS and GMSDs to improve human resource capacities at the GMSDs.	MoHFW and DGHS	31 December 2024	Ongoing. New Deadline 31 December 2025
	Recommendation 11 The UIP should work with the Directorate of General Health to ensure that condemned cold rooms at the GMSDs are decommissioned to free up space so that replacement walk-in cold rooms can be installed.	**Action 11** MoHFW is in discussion with DGHS and GMSDs to improve physical capacities at the GMSDs including decommissioning condemned cold rooms.	MoHFW	31 December 2024	Ongoing. New Deadline 31 December 2025
	Recommendation 12 The MoHFW should develop a standard operating procedure to guide GMSD staff on inventory counts and adjustment procedures. All inventory adjustments in eVIN should be approved by an appropriate level of management.	**Action 12** • Standard operating procedure are available to guide GMSD staff on inventory counts and adjustment procedures. As per the VCCH Module of the UIP (MoHFW), all the store managers/cold chain handlers are supposed to perform the stock count and verify the stock once a month. • The approval for stock edit transactions is a policy level decision which would be taken at the level of MoHFW. **Audit note** The standard operating procedures were not available at GMSDs during audit field work. The MoHFW should: • Disseminate the standard operating procedures to all GMSDs. • Carry out trainings on the SOPs for GMSD staff charged with the responsibility of vaccine stock management.	MoHFW	31 December 2024	Completed
	Recommendation 13 The GMSDs should put in place robust service level agreements with private firms providing cold chain storage services, which includes the stipulation of ensuring proper storage for vaccines	**Action 13** MoHFW is in discussion with DGHS and GMSDs to improve physical capacities at the GMSDs including establishing robust service level agreements with private firms providing cold chain storage services.	MoHFW	31 December 2024	Completed
Stock management practices at subnational level need to be strengthened	**Recommendation 14** The UIP should work with states to strengthen support supervision arrangements related to stock management at the subnational level.	**Action 14** Monitoring & Mentorship has been proposed under HSS3 which will strengthen supportive supervision at various levels of vaccine stores including GMSDs. Monitoring formats have been revised recently for sub national cold chain points and further monitoring formats shall be developed for higher stores like GMSDs, SVS etc.	MoHFW	31 December 2024	Ongoing. New deadline: 30 June 2025
	Recommendation 15	**Action 15** As indicated on Action 12, the VCCH Module of the UIP (MoHFW), requires that all store managers/cold chain	MoHFW	31 December 2024	Completed

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
	The UIP should work with states to provide training and standard operating procedures and/or job aids for sub national level staff on: • Recording the results of each physical stock count, investigating the variances, reconciling with the stock records, and documenting the whole process along with justification for adjustments; and • Reviewing the consumption patterns at the corresponding subsidiary level before re-supplying their direct reports with further vaccines.	handlers perform a stock count and verify the stock once a month. The MoHFW will work with states under HSS-3 to: • Disseminate the standard operating procedures to all states. • Carry out trainings on the SOPs for state staff charged with the responsibility of vaccine stock management.			
Temperature monitoring and mapping was inadequate and needs to be addressed	**Recommendation 16** The UIP should develop and disseminate work instructions/procedures on temperature monitoring and documentation during transit and on receipt of vaccines at the vaccine handling points.	**Action 16** UIP will develop necessary SOP & guideline for temperature monitoring during transit and on receipt of vaccines at the vaccine handling points.	MoHFW & NCCVMRC	31 December 2024	Completed
	Recommendation 17 The UIP should work with the NCCVMRC to develop guidelines for GMSDs and states on temperature mapping and ensure that eVIN modules are activated. Costing for alerts should be completed and evaluated for frequency and functionality.	**Action 17** UIP will work with the NCCVMRC to develop guidelines for GMSDs and states on temperature mapping and ensure that eVIN modules are activated.	MoHFW & NCCVMRC	31 December 2024	Completed
The scope of Immunisation Action Group needs to be expanded to ensure sustainability as the country transitions out of Gavi support	**Recommendation 18** The UIP should document the mandate of the IAG to include: • The scope of oversight within the immunisation programme to include all immunisation activities in addition to Gavi grants; • Requirement for members to adhere to conflict-of interest declarations best practice; • Representation from varied stakeholders that implement the immunisation programme including states and CSOs. • Frequency of meetings; and • Areas of oversight including programmatic, operational, and financial management for grantees.	**Action 18** • The scope of IAG has been expanded to review all aspects of UIP (beyond Gavi support) oversight including programmatic, operational, and financial management for grantees. • States, districts and CSOs now have representation at the IAG. • The IAG will meet on a quarterly basis during HSS-3	MoHFW	31 December 2024	Completed
The implementation of previous EVM assessment recommendations was not yet complete	**Recommendation 19** The MoHFW should: • Assess whether the status of implementation of EVM recommendations and assess whether actions taken thus far mitigate the impact of the findings of the EVM report. UIP should develop a costed action plan to address the additional gaps identified through this assessment; and • Consider an updated EVM assessment using the new EVM2 tool to provide a more comprehensive review of the status of vaccine management	**Action 19** • NCCMIS has a cIP tracking Tool for monitoring implementation of EVM recommendations. • In the recent IAG, NCCVMRC has been instructed to provide the National EVM report for the recent EVM assessments held in 2022 and further share the improvement plans (including costed plans) to streamline the proposals under state programme implementation plan (PIP).	MoHFW & NCCVMRC	31 December 2024	Ongoing. New deadline: 31 December 2025

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
Delayed implementation of Measles-Rubella Campaign in West Bengal and New Delhi	**Recommendation 20** The UIP should work with the two states (West Bengal and New Delhi) to ensure that the campaigns are completed as planned. Results from these campaigns, including lessons learned from the overall Measles-Rubella campaign should be shared with Gavi to inform the organisation learning agenda.	**Action 20** • MR campaigns were completed in both the states i.e., West Bengal and New Delhi with coverages of 91% and 92.7% respectively. • Lesson learnt from MR campaigns will be shared with Gavi. • The two states had already included MR vaccine under routine immunisation.	MoHFW	31 December 2024	Completed
There were gaps in financial internal controls resulting in questioned expenditure	**Recommendation 21** To resolve the gaps noted in the operating effectiveness of the MoHFW's oversight over Gavi funds disbursed by UNICEF to CSOs and government agencies, we recommend that: • All implementing partners (CSOs and government agencies) prepare detailed reconciliations of funds received from UNICEF. These reconciliations should include source of funding; • MoHFW liaise with UNICEF to ensure that the templates for the FACE forms enable implementing partners to report on all expenditure by source of funding; and • MoHFW liaise with UNICEF to conduct a thorough review and reconciliation of all expenditures reported by implementing partners, including supporting documents before expenditure is liquidated. This recommendation should be implemented with reference to the global HACT mechanism that informs the UNICEF's financial management approach and processes.	**Action 21** The discrepancy observed by the audit team between the reported expenditure and Funding Authorisation and Certificate of Expenditure (FACE) Form is due to multiple sources of funding being used in a single FACE form, since partners implement activities beyond immunisation. Going forward, • Implementing Partners will be asked to submit separate FACE Forms for activities supported by Gavi. UNICEF will advise the partners on what activities will be funded by Gavi to facilitate the process. • During liquidation of FACE Forms, a review to be done by UNICEF of reported expenditure against advance approved by ensuring that the actual expenses incurred are aligned to agreed budget in Itemised Cost Estimate (ICE) format and also that there is no deviation beyond 20% of the approved budget. In case any deviation is noted, UNICEF will ensure that the approvals are taken on a prior basis and are documented. • As a remedial measure, UNICEF will plan to hold a refresher orientation of the partners on HACT procedures and processes to ensure that the supporting documentation is effectively maintained by the partner and that no unapproved/unsupported/ineligible expenses are claimed by the partner. • Verification of supporting documents and authenticity of transactions can be investigated during the planned HACT assurance activities (Spot Checks, Program Monitoring Visits, Scheduled Audits, etc.) as per the standard policy.	MoHFW	31 December 2024	Ongoing. New deadline: 31 December 2025
	Recommendation 22 UIP should ensure that reports presented to the IAG by HSS Implementers indicate funding advanced to CSOs and	**Action 22** • With the support of Community of Practice on Demand (CoPD) which has been proposed under HSS-3, a stringent	MoHFW	31 December 2024	Ongoing. New Deadline: 31

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
	Government agencies. The reports should also provide comparative financial performance of CSOs and government agencies.	oversight mechanism will ensure the transparent and effective engagement of CSOs. • Reports on funds advanced to CSOs as HSS implementers will be presented to the IAG on a regular basis.			December 2025
Some Gavi-funded expenditures did not demonstrate value for money	**Recommendation 23** Following the approval of funding for HSS 3, U-WIN will now be utilised as the immunisation registry for UIP. We recommend that UIP: • Documents and approves a plan on how ANMOL will be utilised for other RMNCH+A services in the states to ensure that this investment is sustained; and • Review the integration of ANMOL and UWIN through established dashboards to ensure completeness of information and that one source of data entry is used.	**Action 23** U-WIN developed for Routine Immunisation has been integrated with ABDM (Ayushman Bharat Digital Mission) for the components of Health Facility Registry, Health Professionals Registry and ABHA (Ayushman Bharat Health Account) ID for citizens. U-WIN has been made ABDM compliant to ensure inter-operability with any other software, which is there/further developed under the overarching umbrella of ABDM. • The Gavi implementing partner and MoHFW will encourage utilisation of ANMOL Tablets for U-WIN data entries. • ANMOL will continue to be used for RCH services and there is already a plan to integrate the immunisation data on UWIN with RCH data once the new version of RCH is implemented.	MoHFW	31 December 2024	Completed
	Recommendation 24 For any future surveys funded by Gavi, we recommend cascading approvals for funding at multiple stages to ensure that funds are only released when key activities are approved. The UIP should ensure that: • Key milestones are developed and signed off by MoHFW. These milestones should then be utilised to determine release of funds at each stage; • Preliminary survey design and methodology should be signed off; • Pre-testing of survey methodology should be agreed upon and signed off after the initial pilots; and • Final survey design and methodology should be agreed upon and signed off before data collection, analysis and reporting	**Action 24** MoHFW will ensure cascading approvals for further surveys proposed under HSS-3 to ensure that funds are only released when key activities are approved. This will be implemented subject to approval of HSS 3. Cascade of activities will include but is not limited to; • Development of key milestones and signoff by MoHFW. These milestones should then be utilised to determine release of funds at each stage. • Sign off on preliminary survey design and methodology. • Agreement and signoff on pre-testing of survey methodology after the initial pilots. • Agreement and sign off on final survey design and methodology before data collection, analysis and reporting. • Agreement and sign off on draft report with comments to facilitate finalisation.	MoHFW	31 December 2024	Ongoing. New Deadline: 31 December 2025
Inconsistencies in administrative	**Recommendation 25** UIP should work with the states to:	**Action 25**	MoHFW	31 December 2024	Ongoing. New deadline: 31

Findings	Audit Recommendations	Management Action	Action Owner	Timelines	Status as on 9 April 2025
immunisation coverage reports	• Routinely perform a triangulation of their immunisation data between doses distributed, vaccine utilisation and administrative coverage; and • Consistently complete data verification and validation exercises at the health facility levels	UIP has a planned intervention i.e., Data analytics for RI review under HSS-3. Activities planned under this intervention include: • Data validation. • Data validation Committee meetings are planned under HSS-3. • Data triangulation from all the data sets to overcome gaps			December 2025
There were gaps in the quality of immunisation data	**Recommendation 26** UIP should design and put in place a consistent process that systematically identifies and corrects data anomalies at both national and sub-national levels. Additionally, UIP should work with the state-level data teams to ensure that immunisation data is regularly reviewed and compared to underlying records at both the health facility levels and that the results of this process are documented.	Action 26 U-WIN will be instrumental in improving the recording & reporting at the field level and further improve the data quality. The pilot on UWIN is completed and will now be scaled up to ensure that: • IMI 5.0 and UIP reports are generated and available. • Dash boards to assist in the review and analysis of data at national and subnational levels are developed. • Reviews with state level data teams is done on an ongoing basis. • Data analysis of UWIN and its triangulation with other data sets is done to overcome data anomalies at national and sub national level. • UWIN data is integrated with HMIS or UWIN data is uploaded onto HMIS.	MoHFW	31 December 2024	Ongoing. New deadline: 31 December 2025
Monitoring of the CCE functionality was inadequate	**Recommendation 27** NCCVMRC should work with states to conduct routine calibration, lubrication, and cleaning of the CCE and cold chain trucks to ensure that they provide accurate and reliable temperature readings.	**Action 27** NCCVMRC and MoHFW will work with states to conduct routine calibration, lubrication, and cleaning of the CCE and cold chain trucks to ensure that they provide accurate and reliable temperature readings.	MoHFW & NCCVMRC	31 December 2024	Ongoing. New deadline: 31 December 2025
	Recommendation 28 NCCVMRC should work with states to incentivise the use of NCCMIS to track CCE maintenance. Old equipment should be decommissioned and disposed to create space for new equipment.	**Action 28** NCCVMRC will work with work with states to: • incentivise the use of NCCMIS to track CCE maintenance. • Decommission and dispose old equipment to create space for new equipment.	MoHFW & NCCVMRC	31 December 2024	Ongoing. New deadline: 31 December 2025

Annex 12: Detailed management responses

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
The transition and long-term sustainability of eVIN's operational costs remains a persistent challenge	**Recommendation 1** To ensure the long-term sustainability of eVIN MoHFW/UIP should collaborate with the UN partner and states to: • Strengthen ownership and prioritisation of eVIN at the state level through formal communication from MoHFW, acknowledging eVIN as the vaccine supply chain logistics management platform. The communication should also include clear timelines for the release of funds for eVIN operations. This should be supported by regular updates and follow-ups via the IAG or mechanism deemed appropriate by MoHFW. • Develop a capacity building plan for the systems specialists at UIP, based on a capacity assessment to build the skills and capabilities of UIP staff responsible for the ongoing maintenance and management of eVIN.	**Action 1** 1. The issue raised in the audit has been duly addressed through the progressive strengthening of the Electronic Vaccine Intelligence Network (eVIN) by the Ministry of Health & Family Welfare (MoHFW) over time. A robust framework has been established to ensure the optimal functioning of critical interventions in a sustainable and self-reliant manner. Comprehensive measures have been instituted to enhance system resilience and operational efficiency, resulting in the evolution of a sustainable and self-sufficient model for eVIN implementation across the country. Accordingly, the eVIN management system has been comprehensively streamlined to facilitate efficient and independent management of eVIN at the State/UT level. 2. The maintenance of eVIN has now transitioned to a self-reliant and sustainable model under country ownership. All major components of eVIN are fully owned by the Government, and all associated functions, including server hosting, maintenance, and related operational costs, are being managed by the country itself. This transition ensures the long-term sustainability, continuity, and effective functioning of the eVIN system. Therefore, the eVIN system continues to remain fully functional and operational across all States/UTs under a well-established, self-reliant, and sustainable implementation framework. The requisite institutional and operational mechanisms have been put in place to ensure its continued effectiveness and long-term sustainability. Given the above inputs, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 1** MoHFW (UIP) and State Health Departments with support from UNDP	**Action 1** June 2027
	Recommendation 2 To ensure that a long-term solution for the overdue payments is resolved, MoHFW and Gavi, together with the UN partner should:	**Action 2** 1. The issue stands largely resolved with robust communication between the concerned stakeholders. No grievance on this matter stands pending from UNDP. 2. UNDP has been intimated to share further details with Gavi as proposed by the Audit team.	**Action 2** MoHFW (UIP) and State Health Departments with support from UNDP	**Action 2** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	• Determine a timeline for the collection of all overdue amounts to ensure timely collection and resolve all amounts that cannot be repaid. • The UN partner should maintain an aging schedule for all funds borrowed from Gavi HSS by state and share this with Gavi and MoHFW leadership on a quarterly basis to ensure transparency in this process.	Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**		
The design of eVIN requires further enhancement to optimise operational efficiency	**Recommendation 3** To address the design challenges identified in eVIN, UIP in coordination with the Health Informatics Division of MoHFW and the technical UN partner should: • Establish ongoing data quality reviews by implementing regular system assessments. The assessments should systematically address all design flaws identified in this audit and maintain a tracker for both these issues and any operational problems reported by the states, ensuring timely resolution. Data quality review processes should be included in the final eVIN system handover guidelines. • Consistently verify the accuracy of inventory data by monitoring eVIN entries for discrepancies, investigating any unusual patterns, and ensuring timely correction of any issues identified. • Designate a responsible owner within MoHFW/UIP to manage data quality assurance processes, with clear reporting lines to the established governance structures at UIP.	**Action 3** 1. A strong inbuilt review and governance mechanism for eVIN is already operational within the country under the Universal Immunisation Programme, with complete country ownership of eVIN. A self-sustaining model has been institutionalised at multiple levels, ensuring continuous oversight, accountability and long-term sustainability of eVIN independently. 2. Further, inputs received from UNDP on the issues raised are shared below: 2a) Additional checks have been incorporated in the stock edit transactions wherein the cold chain handlers declare that the transaction has been approved by their supervisors. 2b) As per the current design of eVIN, none of the lower stores (receiving stores) can view the stock of the Higher stores (Issuing stores) 2c). eVIN has transitioned to a Big Data architecture for its database. With this shift, the reports module has been completely overhauled, eliminating any discrepancies or disconnects between the state and national levels. 2d) Further, the ability to download up to 6 months of transactions is intentional to ensure both data integrity and privacy. The above observations reaffirm that the eVIN platform has been continuously strengthened through appropriate technological enhancements and remains a robust, secure and sustainable country-owned system operating effectively under the established governance framework of the Universal Immunisation Programme. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 3** MoHFW (UIP) with support from UNDP	**Action 3** June 2027
User proficiency needs to be strengthened	**Recommendation 4**	**Action 4**	**Action 4**	**Action 4** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
across all eVIN modules	To enhance user proficiency in utilising all modules of the eVIN system, including report downloads, the UIP/MoHFW, in collaboration with its technical partner, should: • Organise refresher trainings across all states to reinforce knowledge and address evolving needs. • Distribute eVIN training manuals to all vaccine handling points at every level and actively encourage vaccine handlers to refer to them regularly to ensure optimal system usage. • Integrate refresher training materials into platforms such as ITMIS and U-Mentor, where applicable, to help mitigate challenges arising from staff turnover.	1. UNDP has informed that soft copies of the eVIN training manuals are made available to all users. This is an ongoing process, and whenever modules, SOPs, or guidelines are updated, the revised versions are regularly shared with users. 2. It is reiterated that India has a robust institutional mechanism for regular capacity building/refresher trainings under the Universal Immunisation Programme. With complete country ownership of eVIN, continuous training and operational strengthening are being independently sustained through established UIP systems. Appropriate mechanisms for continuous knowledge sharing, capacity building, and operational continuity have been institutionalised, ensuring the sustainable and independent management of eVIN within the framework of the Universal Immunisation Programme (UIP). Accordingly, based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	MoHFW (UIP) with support from UNDP	
Data quality issues continue to affect accuracy and completeness of reporting	**Recommendation 5** To improve data quality in eVIN, MoHFW/UIP in collaboration with its technical partner and State health departments should: • Ensure that all stock receipts and issuances are entered in eVIN on real time basis with backdated data entry restricted to a reasonable period to encourage on time recording. • Ensure that vaccine handling points should conduct investigations for stock discrepancies noted following physical count. • Design functionality for stock take recording within eVIN • Distribute the SOP on stock edits in eVIN and ensure its implementation at all the vaccine handling points	**Action 5** 1. The issues have been duly addressed through the strengthening of internal systems and processes, ensuring an appropriate level of management and oversight. 2. UNDP has informed that the mentioned issues have been resolved and has shared the following inputs: 2a) The supporting document regarding the transactions older than 15 days cannot be performed in eVIN. 2b) The SOP of the stock edit process is ongoing and will be completed. The above confirms that the identified issues have been duly addressed and the necessary corrective measures have been implemented to strengthen the operational functioning of eVIN. Accordingly, based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 5** MoHFW (UIP) with support from UNDP	**Action 5** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
Enhancements are needed to optimise the temperature monitoring function	**Recommendation 6** To enhance the temperature monitoring function of eVIN, MoHFW/UIP in collaboration with its technical partner and State Health Departments should: • Identify deficiencies in temperature logger availability and install loggers on all CCE used for vaccine storage • Develop and/or update preventive maintenance protocols for CCE to include maintenance of eVIN temperature loggers as CCE accessories and maintain adequate documentation. • Prepare schedules for conducting periodic temperature mapping for WICRs and WIFRs and conduct regular temperature mapping as per WHO guidelines	**Action 6** 1. It is an ongoing/regular activity, as the concerned States/UTs propose temperature loggers in their respective State/UT PIPs based on their requirements, including procurement of new loggers or replacement of existing ones. Upon approval in the RoP, the States/UTs undertake procurement and installation of the loggers accordingly. 2. UNDP has shared the troubleshooting manual for temperature loggers. Hence, the above demonstrates that a well-established mechanism for procurement, maintenance and operational support of temperature loggers is already in place. 3. India has a robust and well-established vaccine supply and cold chain management system under the Universal Immunisation Programme, governed by standard protocols & guidelines which address such requirements as per UIP programmatic needs. Therefore, India already has a robust institutional framework and established systems in place to self-reliant manage such programmatic requirements under the Universal Immunisation Programme 4. Further, this specific recommendation is not covered within the current scope of the Gavi partnership framework. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 6** MoHFW and State Health Departments with support from UNDP	**Action 6** June 2027
NCCMIS continues to face design limitations and is not being fully utilised	**Recommendation 7** To enhance the utilisation of NCCMIS, the MoHFW/UIP in collaboration with the state health departments should: • Advocate for utilisation of NCCMIS by expanding the user base including provision of user rights to CCPs • Conduct a training needs assessment and follow it up with targeted suer training for system users based on areas of weakness identified	**Action 7** This specific recommendation is not covered within the current scope of the Gavi partnership framework. Hence, it indicates that the matter falls outside the current scope of the Gavi partnership framework and is being independently managed by the country through established programme systems under the Universal Immunisation Programme. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 7** NCCVMRC	**Action 7** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	Recommendation 8 To optimise NCCMIS design and functionality, the MoHFW/UIP, in collaboration NCCVMRC should: • Outline a clear roadmap with actionable timelines to implement the integration between NCCMIS and eVIN. This timeline should be agreed in the IAG and followed up in subsequent discussions. • Establish a mechanism to follow-up after assessments are completed for the systems that all recommendations have been implemented • Perform a comprehensive system review to identify system bugs and nonfunctional modules and plan to have these resolved	**Action 8** 1. The NCCMIS and eVIN systems, on a self-reliant mode managed by India under established national systems. The integration of both systems has been meticulously planned in a seamless fashion and will be undertaken accordingly. 2. Further, this specific requirement (regarding sharing security audit report/certificate of NCCMIS) is not covered within the current scope of the Gavi partnership framework. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 8** NCCVMRC with support of UNDP	**Action 8** June 2027
Challenges related to UWIN system integration, access and sustainability need to be addressed	**Recommendation 9** MoHFW in consultation with the technical partner should: • Hasten the integration platform as a critical success factor • In the medium term, consider adoption of alternatives to OTP- for example device based biometric authentication with fallback of local pin or pattern for access to the UWIN platform. OTP failures may likely persist due to intermittent network disruptions while disabling OTP entirely increases the risk of security exposures on UWIN. • In the short term, review the network accessibility challenges, and include a mapping of where such issues exist to formulate solutions for these geographies • Develop system dashboards to track login attempts, OTP failures, and access anomalies, including resolutions to ensure that this knowledge is captured for future handover to MoHFW.	**Action 9** 1. The U-WIN system has been successfully rolled out in the country and is being implemented in the entire country. 2. UNDP has informed that the core team at UNDP India HQ is regularly tracking the challenges (if any) encountered in accessing the U-WIN platform at the field level. 3. Further, U-WIN already provides OTP-based beneficiary verification and an offline module to ensure uninterrupted service delivery in areas with connectivity constraints. The U-WIN is fully operational, with appropriate systems and for being a single source of truth functionalities for already in place for effective implementation across the country. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 9** MoHFW (UIP) in coordination with UNDP	**Action 9** June 2027
	Recommendation 10 MoHFW in consultation with States and technical partner should to:	**Action 10** India has self-evolved several self-reliant digital public health systems and has established strong in-country mechanisms for their long-term sustainability. Similar to eVIN and other digital systems, necessary way forward measures for	**Action 10** MoHFW (UIP) with support of UNDP	**Action 10** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	• Develop a UWIN sustainability and transition plan, clearly detailing future financing, ownership, and institutional responsibilities. • Request and review a comprehensive quantification of all fixed and recurring operational costs for UWIN operations and maintenance. These should also include costs of required server space for all Gavi supported systems and apps. • Identify and quantify the technical capacity need at MoHFW in the first instance, to ensure that all Gavi supported systems and apps have adequate management capacity at this level. • Prioritise early budget inclusion for operational costs in national and state health plans and aligning UWIN with existing national digital health infrastructure to ensure integration and continuity beyond GAVI support.	continued implementation, maintenance and sustainability of the U-WIN is effectively ensured, being the single source of truth for the Immunisation Programme of the country. Hence, the long-term sustainability and continued management of U-WIN will be independently ensured through the country's established institutional mechanisms. India has developed several self-reliant digital public health systems and established strong in-country mechanisms to ensure their long-term sustainability. Necessary way-forward measures, including capacity building, are undertaken as a part of the process management inbuilt for sustenance and management of the eVIN and U-WIN programme to ensure the smooth transition and sustainability of critical digital systems. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**		
UWIN system utilisation requires improvement	**Recommendation 11** To improve utilisation of UWIN, MoHFW/UIP in collaboration with the State Health Departments should: • In the short term, consider lengthening the data entry timeframe by an additional 48 hours to allow data entry after immunisation sessions. • Hasten the integration platform to allow for one point of data entry to lessen burden on the health worker force. • Once integration is complete, agree and update the health records requirements for all HMIS, RCH and UWIN platforms. • Strengthen UWIN monitor system usage through block-wise analytics, identify non-compliant cold chain points, and implement corrective actions, including training, as needed. • Conduct monthly comparisons and generate reports to align data between UWIN and HMIS, ensuring completeness, consistency and accuracy across systems till the time the MoHFW adopts UWIN as the single immunisation data recording system.	**Action 11** 1. The U-WIN reports module is already functional. It supports in monitoring not only block-wise but also Health facility-wise and session site-wise. 2. Regular monitoring of U-WIN is an ongoing activity under the UIP programme. In view of the above, it is observed that adequate system functionalities and regular monitoring mechanisms have been established for the effective implementation of U-WIN under the Universal Immunisation Programme. Accordingly, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 11** MoHFW (UIP) and State Health Departments with support from UNDP	**Action 11** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
There are opportunities to improve the design of the U-Mentor app	**Recommendation 12** To ensure oversight over U-Mentor, MoHFW in collaboration with its technical partner should: • Ensure the IAG maintains ongoing oversight throughout the development of the U-Mentor App. Strengthen the IAG by including an independent IT project management and technical expert, to be appointed by the MoHFW. • In addition to oversight through the IAG, prioritise the institution of a technical oversight function for development work completed by IIT Bombay to ensure all upgrades/updates are developed according to best practices and adhere to set guidelines. • Review the responsibilities of the technical personnel at MoHFW/UIP and assign responsibilities for the U-Mentor app to a technical staff who will follow through the final development and roll out, including integration with other Gavi supported systems. • Upon rollout of U-Mentor, determine the level of integration required or supercede other tools to ensure that data is maintained in one platform as envisioned. • Establish a formal roadmap and timeline for the systematic transfer of all critical administrative rights, system documentation, and source code from the development partner (IIT Bombay) to MoHFW. • Engage in capacity-building to prepare internal teams for ongoing administration, this should be through a structured capacity building plan that includes assessments of degree of skills transfer.	**Action 12** 1. It has been informed by UNICEF that the U-Mentor application has already been "developed", successfully piloted, and is currently being expanded to 13 States. 2. The transition of U-Mentor will necessarily have to be undertaken. Therefore, given the requirement of enabling the sustainable model, the process is on track. The precedent followed for eVIN will be enabled for U-Mentor as well for successful pan India roll out. Therefore, India has the necessary institutional and technical capacity to undertake appropriate measures to ensure the long-term sustainability, self-reliance, and independent management of U-Mentor. Given the above inputs, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 12** MoHFW (UIP) with support from UNICEF	**Action 12** June 2027
	Recommendation 13 This recommendation is written to be more detailed given the technical and project management challenges noted during the audit and at the request of the Gavi implementing partner but does not preclude the partner from understanding and preparing the required checklist. To ensure effective design and use of U-Mentor, MoHFW in collaboration with its technical partner should: • Offer a range of authentication methods beyond OTP, including static passwords, biometric verification, and two-	**Action 13** The issues identified have been duly addressed by UNICEF. The observations furnished by UNICEF regarding the issues raised are reproduced below: 1. To address alternative mechanisms for login, two channels are being used for delivery of OTP, i.e. SMS and email and experiences with the pilot testing and ongoing usage of the application do not warrant the need for any third mechanism for login to the U-Mentor app.	**Action 13** MoHFW (UIP) with support from UNICEF	**Action 13** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	factor authentication options that function independently of consistent internet access. Additionally, establish fallback login mechanisms—such as security questions or secure offline codes—to ensure users can still access their accounts if OTP delivery is unsuccessful. • Work with IIT Bombay to integrate automatic GPS capture within the application, leveraging device capabilities to reduce manual entry. • Maintain secure, regularly updated backup copies of source code and essential data in multiple locations to mitigate data loss risks. • Ensure that a comprehensive security assessment is completed prior to further pilot and/or roll out of the system. • Ensure that all the outstanding 13 issues identified as part of the web testing exercise are resolved and closed off. • Create a detailed handover checklist specifying all necessary deliverables for a smooth transition, including **Technical Documentation** • System architecture documentation • Source code (including repositories and version history) • Database design schema and documentation • API integration documentation (including interfaces with UWIN and any other systems) • Security protocols and standards documentation **Operational and Maintenance Procedures** • Maintenance guide for routine system updates, backups, and recovery procedures • Incident management and troubleshooting guide • Hardware assessment to determine infrastructure required to host system and 5-year buffer given data and user estimates **Testing and Quality Assurance** • Complete documentation of test scenarios, results, and defect logs • Historical and current bug/issue tracking reports • User acceptance testing (UAT) results and sign-off documentation	2. Currently in U-Mentor, GPS capture is a user-initiated action, allowing them to record accurate coordinates when they are in a suitable location. Gavi Audit team may coordinate with UNICEF to check the functionality of the same. 3. All high-priority issues identified during the internal testing were already resolved by UNICEF. Gavi team may coordinate with UNICEF to check the documentation regarding the same. In view of the above, it is observed that the identified issues have been addressed and the requisite system functionalities have been established for the effective implementation of the U-Mentor application. Accordingly, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**		

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	Skills transfer plan • Agreed-upon timeline and detailed schedule for system transition • Knowledge transfer sessions schedule (e.g., technical walkthroughs, training sessions)			
The implementation of RISE requires strengthening	**Recommendation 14** To ensure effectiveness and sustainability of RISE the MoHFW in collaboration with the partner should: • Establish a formal process for periodic review of the RISE platform, covering training content, platform integration, and cybersecurity. Assign a dedicated technical lead within MoHFW to oversee this process and report outcomes to the IAG. • Strengthen state-level ownership and accountability by decentralising operational responsibilities and incorporating RISE-related costs into state health budgets to ensure sustainability. • Develop a comprehensive monitoring and evaluation framework that includes training needs assessments, baseline evaluations, impact measurement linked to key performance indicators, and tracking of pre- and post-training outcomes, including behavioural change metrics. • Integrate RISE with support supervision platforms such as U-Mentor, ensuring that training needs assessments are informed by supervision data. This will enable training modules to directly address gaps identified during health worker evaluations, promoting targeted and effective capacity building. • Ensure functional integration with ITMIS and institutionalise routine immunisation training within the national health system. • Promote digital learning uptake by aligning RISE with national Continuing Professional Development (CPD) policies and frameworks, enabling formal recognition and career progression for health workers.	**Action 14** 1. It has been informed by the JSI that the training content on the RISE platform is being updated periodically. The manual for Health Worker 2024 was released in November 2024, and subsequently, actions were initiated to update the technical content in the RISE modules. Presently, all the RISE modules are “up to date". Further, RISE progress and technical updates are regularly reviewed in IAG/Pre-IAG and other relevant meetings as well. 2. The audit observation requires a review of the system functionality. While the RISE application is used by ANMs, the U-Mentor application is primarily used by their supervisors. U-Mentor has provisions to regularly share consolidated ANM performance scores with program managers. These insights can be utilised to identify training needs, including RISE training/refresher training and physical training/refresher training requirements. 3. Rapid assessments are conducted by JSI to capture the enablers and barriers in accessing the RISE App. As of 31st March 2026, 1057 learners were assessed & 1025 sessions were observed across 320 blocks in 114 districts. Brief analysis of Rapid Assessment (as shared by JSI) is provided. 4. The audit observation requires a review of the system context. Promoting digital learning uptake through alignment of RISE with national Continuing Professional Development (CPD) policies and frameworks falls beyond the purview of the Immunisation Division, MoHFW. 5. With reference to the issue of incorporating RISE-related costs into the state NHM budget has already been settled, and other relevant information is detailed below. 6. As informed by JSI, there is a strong level of ownership and adoption of the RISE app at both the State and District levels. State government training platforms are being effectively leveraged to deliver RISE modules, ensuring active participation. The State provides administrative approvals, facilitates cascade trainings, and actively monitors module completion, taking timely actions to ensure course completion. RISE was planned to be rolled out across	**Action 14** MoHFW (UIP) and State Health Departments with support from UNICEF and JSI	**Action 14** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		246 districts in 7 states in HSS-3. As of now, out of 7 states, RISE has been rolled out in 208 districts across 6 States, i.e., Arunachal Pradesh, Maharashtra, Meghalaya, Rajasthan, Tamil Nadu, and Uttar Pradesh, and in the remaining 1 state, i.e., Bihar. Preparatory activities have already been initiated for the remaining 38 districts. Therefore, the implementation of RISE is on track. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**		
Governance mechanisms should be linked to the MoHFW governance framework	**Recommendation 15** To ensure continued oversight over Gavi-supported programmes and systems beyond Gavi support, the MoHFW should transition and integrate the duties of the IAG within the existing NHM governance framework by: • Ensuring clear linkages on how issues discussed at IAG, in its current format, are escalated to the NHM. • Preparing a comprehensive overview of all Gavi-supported programmes for the NHM governance framework.	**Action 15** 1. With regard to the observation on linkage of IAG with NHM processes, it is informed that the structure of the IAG itself incorporates the antigen-wise coverage and various challenges of the concerned States/UTs in detail for the Universal Immunisation Programme in the country. Since the inherent constituents of IAG entail discussions and deliberations regarding various components of the UIP programme, it is necessary to point out that the subject matter of such deliberations includes, inter alia, all stakeholders involved in managing and running the UIP in the country, including development partners, which is indicated by the progress on coverage already achieving near saturation levels on various antigens. 2. With regard to the recommendation on the continuation or integration of IAG after the conclusion of Gavi support, it is informed that the management and governance of the Universal Immunisation Programme remain within the ambit of the policy and institutional framework of the Government of India. Given that the Universal Immunisation Programme (UIP) has been under implementation since 1985, with a long history of well-established governance and review frameworks, the processes for settlement of issues and integration of programme progress review mechanisms, including IAG, in accordance with the existing Government framework are already in place Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 15** MoHFW (UIP)	**Action 15** June 2027
	Recommendation 16	**Action 16**	**Action 16**	**Action 16** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	To strengthen the IAG before its integration and transition to NHM, the MoHFW should: • Expedite the operationalisation of the CoPD Secretariat to strengthen CSO involvement at the IAG level and ensure strategic alignment with demand generation efforts. • Reinstate quarterly meetings for IAG, Pre-IAG, STFI, and DTFI, with a fixed calendar and designated accountability for follow-up actions to support timely decision-making. • Develop a standardised system for documenting feedback from review and support supervision visits, ensuring insights are captured, shared, and acted upon. • Broaden national-level oversight to include Gavi-supported activities within MoHFW's strategic planning and monitoring frameworks, promoting integration and sustainability. • Create mechanisms to capture ground-level feedback, such as community scorecards or structured CSO reporting, to inform STFI decision-making and improve responsiveness.	1. As informed by UNICEF, the joint work plan of CoPD and UNICEF is already "in place" for CoPD to guide and monitor the work of the CSO. 2. The STFI & DTFI meetings are regularly conducted by the respective States/UTs to review the UIP performance at the State and district levels. 3. The Gavi Audit team may coordinate with UNICEF to check their CSO MIS. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	MoHFW (UIP) with support from UNICEF	
Gavi's strategic partnership support has been under utilised	**Recommendation 17** The MoHFW should: • Develop roadmap for introduction of HPV and TCV and ensure implementation as committed by Government within the 2022-2026 India-Gavi strategic partnership period. • Reprogram the available funding under the mobiliser incentive, following Gavi's reprogramming guidelines.	**Action 17** 1. The national campaign for the HPV vaccine was launched by the Hon'ble Prime Minister of India on 28th February 2026. 2. The communication pertaining to the TCV Vaccine will be made appropriately as per the country's policy framework. The Gavi team has already been apprised of the same during the Joint Appraisal held from 5th to 7th March 2026. 3. Since this MoU is signed between UNICEF and Gavi, the Gavi audit team may coordinate with the concerned Gavi/UNICEF team to check the signed MoU for reprogramming of the mobiliser incentive. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 17** MoHFW (UIP) with support from UNICEF	**Action 17** June 2027
The CSO strategy, design and implementation	**Recommendation 18** The MoHFW in coordination with the CoPD secretariat and technical partners should:	**Action 18** 1. It is informed by UNDP that CoPD holds regular coordination meetings with UNICEF, WHO, Gavi, and CSOs.	**Action 18**	**Action 18** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
experienced significant delays	• Establish the CoPD secretariat meetings, with agreed frequency and oversight over work done by the CSOs and technical partners. • Review CSO activities and recalibrate the current plan and approach based on agreed recommendations from the CoPD reviews with a focus on implementation, reduced overlaps and sustainability planning • Update CSO terms of references to reflect changed activities and responsibilities • Ensure that the CoPD secretariat prepares and presents progress reports on the CSO strategy and implementation in the IAG meetings.	2 Further, it has been informed that the joint field visits and district-level consultations have been completed to ensure ground-level alignment. A series of Co-Design workshops using a Human-Cantered Design approach are being conducted with FLWs, PRIs, CSOs, UNICEF, and district officials. Learnings from these workshops are shaping context-specific, tailored strategies and communication/behavioural tools for CSOs to drive vaccine demand. With MoHFW approval, formative research in low-uptake geographies has been completed. Insights are directly informing the development of new demand-generation tools by CoP-D. 3. Also, CoPD and UNICEF have conducted the CSO Co-Learning Workshop on 2nd and 3rd June 2026 with all the CSOs to: -Share CSO interventions, field experiences, and innovations- Disseminate CoPD research findings and learnings to integrate communication/behavioural tools into CSO-led community interventions. 4. The appropriate coordination and review mechanisms are already in place to ensure regular oversight of CSO activities and continuous refinement of demand-generation interventions under the existing implementation framework. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	MoHFW (UIP) with support from UNDP	
There were gaps in financial internal controls resulting in questioned expenditure	**Recommendation 19** While the Gavi funding was received by a Gavi implementing partner, the overall responsibility for overseeing Gavi investments is the MoHFW. To resolve the gaps noted in the operating effectiveness of the oversight over funds disbursed to CSOs and government agencies, we recommend that the MoHFW ensures that: • All implementing partners (CSOs and government agencies) prepare detailed reconciliations of funds received from the Gavi implementing partner. These reconciliations should include source of funding and should be annexed to the face forms; and • The UNICEF conducts a thorough review and reconciliation of all expenditures reported by implementing partners,	**Action 19** 1. As shared by UNICEF, the schedule of spot-checks and Programme Monitoring Visits (PMVs) for CSO partners of UNICEF working for Gavi HSS-3 is provided. 2. Further, the findings of spot-checks and PMVs can be shared directly by UNICEF with the PwC team (Gavi assurance provider) quarterly, as per the suggestion of Gavi. Based on the information provided above, the audit observations are deemed as settled. **Audit Note - The audit notes the management response and will follow up as part of the follow up of the recommendations in this report.**	**Action 19** MoHFW (UIP) with support from UNICEF	**Action 19** June 2027

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	including supporting documents before expenditure is liquidated. • The role and involvement of assurance provider is re-evaluated to ensure proper accountability over financial management procedures at CSOs and Government agencies.			