



PROJECT DOCUMENT

[Country: India]

Project Title: Improving Efficiency of the Vaccination System in India

Project Number: 01001150

Implementing Partner: UNDP

Start Date: 01.08.2023** **End Date:** 31.12.2026

PAC Meeting date: 19.06.2024

Brief Description

The Government of India's (GoI's) Universal Immunisation Programme (UIP) aims to provide access to vaccines to pregnant women and children. As per HMIS (2022-23), the Penta-3 coverage in India is 94%, however, there are an estimated 1.5 million unvaccinated and under-vaccinated children (Immunization Division, Ministry of Health and Family Welfare, Government of India).

In partnership with the Ministry of Health and Family Welfare (MoHFW), the National Health Mission, Gavi, WHO, UNICEF and UNDP will promote innovative and scalable solutions on digitalization in the health sector, in an inclusive manner, to ensure universal vaccination of all pregnant women and children. This system will also support the GoI in tackling any future health emergencies effectively and efficiently. UNDP will build on its previous work with the MoHFW on the Electronic Vaccine Intelligence Network (eVIN) to digitalise the vaccine supply chain and Co-WIN for the digitalisation of COVID vaccination beneficiary management. Besides, UNDP will support data triangulation of multiple data sets in place to monitor immunisation services and strengthen data review mechanisms at the last mile.

Immunization programme partners will engage with local organisations for demand generation and community engagement on immunization. Besides, UNDP will support in establishing a "Community of Practice (CoP)" for demand generation to streamline engagement strategies and adherence to policies and guidelines of the Ministry of Health and Family Welfare.

This project will provide technical assistance for a robust and resilient immunization system. UNDP will digitalise all aspects of registration & vaccination of pregnant women and children, track the real-time vaccination status of all the vaccines offered by the national immunization programme, and closely monitor the field mobilisation of beneficiaries, to improve the efficiency of the vaccination system in India.

Contributing Outcomes, Outputs and Indicators (UNSDCF, CPD):

UN Sustainable Development Cooperation Framework (2023-2027)

Outcome Area 1: By 2027, communities, especially the most disadvantaged, demand for and benefit from inclusive, universal, affordable, accessible, accountable, and quality healthcare services, while adopting positive health practices.

Outcome Indicator: % Children (ages 12-23 months) fully immunised.

Baseline (2021): Total: 76.4%; Target (2025): Total: 90%

Output Indicator 1.2.4: Number of districts that institutionalised the real-time digital tracking of routine immunisation beneficiary coverage.

Baseline (2022): 0; Target (2027): 734

UNDP Country Programme document for India (2023–2027)

Output 1.2: Improved service delivery of health care and development programmes to the last mile to ensure that no one is left behind.

Output Indicator 1.2.1: Number of states that institutionalized the strengthened systems for health and development programmes for equitable access to services.

Baseline (2022): 0 Target (2027): 36 States and UTs

Output Indicator 1.2.3: Number of people that benefited from the strengthened systems on health and development programmes.

Baseline (2022): 0 Target (2027): 150 million

Gender marker: GEN2 (Gender equality is a significant objective)

Total resources required			\$62,955,152
Total resources allocated	Donor (Gavi)	Health System Strengthening (HSS) – Phase III and related Technical Assistance	
		– U-WIN	\$39,646,708*
		– Immunization Data Analytics	\$12,540,657*
		– CoP-D	\$10,767,787*
	UNDP		Nil
			Nil
	In-Kind		Nil

Agreed by UNDP (signatures)
Amended on

Print Name: Angela Lusigi,
Resident Representative, UNDP India

Date:

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Angela Lusigi
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*Resources allocated towards the Initiation Plan (PIP) is included.

** Dates including of pre-project activities

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1. DEVELOPMENT CHALLENGE (1/4 PAGE – 2 PAGES RECOMMENDED)

Background

Among the Sustainable Development Goals, Goal #3 for ‘Good Health and Well-being’ is about ensuring healthy lives and promoting well-being for all, at all ages. More specifically, Target 3a works towards reducing the global maternal mortality ratio and Target 3b works towards ending preventable deaths of newborns and children under 5 years of age.

Providing access to affordable vaccines is considered the most cost-effective public health intervention, largely responsible for reducing vaccine-preventable diseases. The **immunization programme of India** is an integral part of the country’s National Health Mission (NHM) and Reproductive and Child Health (RCH) programmes. The immunization services are programmatically and financially supported by the Programme Implementation Plans (PIPs) budgets of the states, under the overall leadership and direction of the immunization division of the Ministry of Health and Family Welfare (MoHFW) of the Government of India. These vaccines are available to all children and pregnant women, including non-migratory and migrants, people from remote geographies and high-risk areas, tenants, labourers, at nomadic sites, brick kilns, construction sites, and others¹, irrespective of whether their names are in records or not.

The national immunisation programme of India known as the **Universal Immunization Programme (UIP)** is one of the largest in the world, with an annual reach of over 27 million children and 30 million pregnant women through **12 million routine immunisation (RI) sessions planned every year**.^{2,3} The programme has been providing the following eleven free-of-cost vaccines against vaccine-preventable diseases:

- BCG - Bacille Calmette-Guerin (for childhood tuberculosis)
- DPT - Diphtheria, Pertussis and Tetanus Toxoid
- HepB - Hepatitis B
- IPV - Injectable Polio Vaccine
- JE - Japanese Encephalitis
- MR - Measles and Rubella
- OPV - Oral Polio Vaccine
- PCV - Pneumococcal conjugate vaccine (for Pneumonia)
- Penta - Pentavalent (for Diphtheria, Pertussis, Tetanus, Hepatitis B and Haemophilus influenzae type B (HiB))
- Td - Tetanus and adult Diphtheria
- RVV - Rotavirus Vaccine

For the implementation of the immunization program, India has set up a vast network of nearly 29,500 vaccine storage points, known as **Cold Chain Points (CCP)**, co-located at public health hospitals, community health centres, primary health centres and other health facilities. These CCPs store vaccines and deliver immunization services from fixed centres and outreach session sites. Across these CCPs, vaccines are stored in more than 60,000 refrigerators and deep freezers, known as **Cold Chain Equipment (CCE)**. Walk-in-coolers and freezer rooms are set up to store vaccines at bulk storage locations. These CCPs distribute vaccines to session sites, where nearly 12 million routine immunization (RI) sessions are conducted annually⁴.

¹ Operational Guidelines: Intensified Mission Indradhanush 4.0, 2022, MoHFW
https://imi4.mohfw.gov.in/assets/document/operational/IMI4.0_operational_guidelines.pdf

² <https://main.mohfw.gov.in/sites/default/files/Universal.pdf>

³ Gurnani V, Halder P, Aggarwal MK, et al. Improving vaccination coverage in India
<https://www.bmj.com/content/363/bmj.k4782>

⁴ <https://main.mohfw.gov.in/sites/default/files/Universal.pdf>

Problem Analysis

Despite decades of progress in increasing access to immunisation, India currently accounts for 11% of the 20 million unvaccinated and under-vaccinated children globally. For this 20 million, gender-disaggregated data is not provisioned in the existing data sources. The country is moving fast to achieve universal immunisation coverage and meet the goals of the UN Sustainable Development Framework's Immunization Agenda 2030 (IA2030)⁵. These partially immunized and non-immunized (zero-dose) children are at higher risk of morbidity and mortality due to vaccine-preventable diseases. It is critical to identify and vaccinate these children, who are widely distributed across the country. In India, zero-dose children remain concentrated among caregivers (mostly mothers) from the bottom wealth quintile, with no education, located in less developed geographies. Caregivers may lack information and awareness on the benefits of vaccination, also the low socio-economic status of caregivers or lack of women's access to household funds may limit the means to afford indirect costs of vaccination (Transportation, etc). Zero-dose children are more likely to suffer from malnutrition than vaccinated children. Interventions that address this cycle of intergenerational inequities should be prioritised⁶.

Among women, maternal and neonatal tetanus and diphtheria can occur during pregnancy or within 6 weeks of child birth. The high occurrence of maternal and neonatal tetanus is an indicator of disparity and inequity in health care for women.⁷ The Td vaccines given during antenatal care or during institutional delivery reduce the rate of maternal and neonatal tetanus & diphtheria and prevent mortality or morbidity. NFHS-5 reveals that 92% of pregnant women received recommended dosages of TT/Td vaccines.

While immunisation now reaches more communities (Migrants, construction site workers, resistant families, etc) than most other routine health interventions, India is still far from the goal of leaving no one behind with immunisation. Despite being operational for many years, India's immunization programme has only been able to **fully immunize only 76.4% of children** between the age of 12-23 months⁸. Further, Gender disaggregated data is not provisioned in the existing data sources.

The Covid-19 pandemic accentuated the health challenges and unmasked the sub-optimal resilience of the healthcare system. During the lockdown, there were major disruptions in health services, especially in reproductive and child health services. The National Health Management and Information System (HMIS) reported a substantial decrease in routine immunization services relative to the previous year, indicating that many children missed their vaccines⁹. To achieve universal immunisation coverage, India requires a sustainable and multi-pronged mechanism for reaching zero-dose and partially immunized pregnant women and children.

As per the SRS, there is a sharp decline in under-5 mortality rates from 45 (SRS 2014) to 32 (SRS 2020) per 1,000 live births. The results of the National Family Health Survey (NFHS), India, rounds 3 (2005-06), 4 (2015-16) and 5 (2019-21) indicated a decrease in under-5 mortality rates from 61.7 (NFHS-3) to 49.7 (NFHS-4) to 41.9 (NFHS-5), per 1,000 live births. This can be attributed to the increase in fully

⁵ <https://www.who.int/publications/m/item/progress-and-challenges-with-achievinguniversal-immunization-coverage>

⁶ Mira Johri, Sunil Rajpal, S V Subramanian. Progress in reaching unvaccinated (zero-dose) children in India, 1992–2016: a multilevel, geospatial analysis of repeated cross-sectional surveys. The Lancet Vol 9 December 2021.

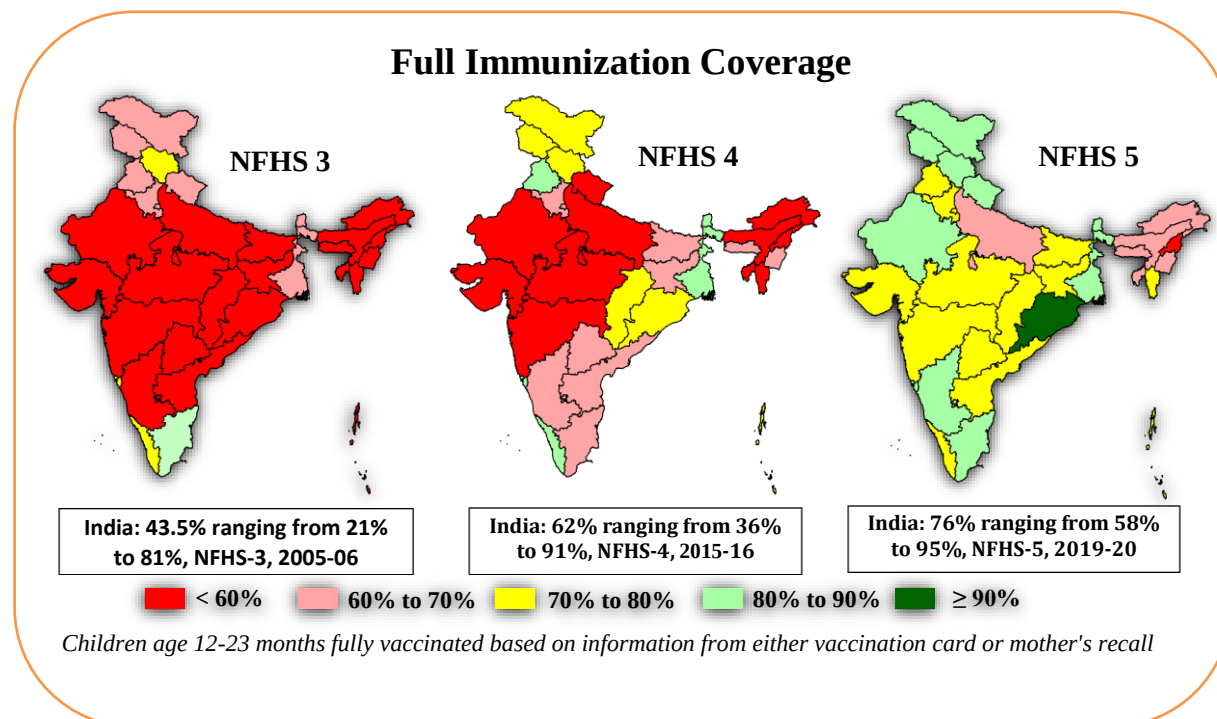
⁷ <https://www.who.int/southeastasia/activities/sustaining-maternal-and-neonatal-tetanus-elimination/maternal-and-neonatal-tetanus-elimination#:~:text=Maternal%20tetanus%20is%20defined%20as,occur%20with%20neonatal%20tetanus%20elimination>

⁸ National Family Health Survey - 5, 2019-21, India

⁹ <https://www.livemint.com/news/india/how-covid-19-response-disrupted-health-services-in-rural-india-11587713155817.html>

vaccinated children aged 12-23 from 43.5% to 62.0% to 76.4% over a span of one and a half decades. Although there is overall progress in immunization coverage, the progress is not uniform across states and districts. The immunisation coverage in different states ranges from 71% to 100% in 2019-20. (Box: 1).

Box 1: NFHS 3, 4, and 5 Immunization Coverage 12-to-23-month Children, India



The progress in coverage is not uniform in urban and rural areas. The vaccination coverage was lower in rural (39%) than in urban (58%) areas in 2005-06 (NFHS-3) but, by 2019-20 (NFHS-5), the rural coverage was at 76.8%, slightly higher than urban (75.5%). Over a span of 15 years, the coverage gain is 25% in rural and only 11.5% in urban areas. The challenges in enhancing urban immunization coverage include high migration, rapid urbanization, shortage of healthcare providers and workers, poor infrastructure, and vaccine hesitancy.

Further, there are wide inequities in the uptake of immunization services, as NFHS-5 reported that¹⁰

- Children of educated mothers are more likely to receive vaccinations.
(80% of children whose mothers have 12 or more years of schooling have received all vaccinations, compared with 68% of children whose mothers have no schooling).
- Children of minorities are less likely to receive all basic vaccinations.
- Children of first birth order are more likely to receive vaccinations
- Vaccination coverage increases with increasing wealth status
(79% of children aged 12-23 months from households in the highest wealth quintile received all basic vaccinations, compared with 71% of children from households in the lowest wealth quintile).
- Coverage of all basic vaccinations varies considerably by state and union territory.
(highest coverage in Dadra & Nagar Haveli and Daman & Diu (95%), Odisha (91%), Tamil Nadu (89%), and Himachal Pradesh (89%) and lowest in Nagaland (58%), Meghalaya (64%) and Arunachal Pradesh (65%)).

¹⁰ International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), 2019-21. Section 9.2 Vaccination of children. page 324.

- There are 3.2% home births (Rural Health Statistics 2021-22) but there is also a reduced number of ANMs to assist home births which poses a challenge to immunisation for pregnant women and children.

One of the key challenges in achieving full immunisation coverage includes a lack of data to take immediate corrective actions for immunization for pregnant women or children¹¹. The Ministry of Health and Family Welfare along with State Governments have multiple Management Information Systems (MIS) and reporting mechanisms to capture the immunisation service delivery such as HMIS, RCH, eVIN, NCCMIS, Techo, eKavach, PICME, etc. However, these data sets are operating in silos and not converting into meaningful dashboards. Besides, these data sets are not part of regular and periodic review meetings at districts, block and facility levels for programme improvement. Hence, there is a need to set up a platform to ensure data triangulation, completeness, quality assurance, integration and capacity for data analysis. Which further enhances the effective reach and equitable access to “leave no one behind”.

Further, significant gender-related barriers exist for achieving full immunization coverage including:

- caregivers may lack information and awareness on the benefits of vaccination.
- low socio-economic status of caregivers or lack of women’s access to household funds may limit means to afford indirect costs of vaccination (transportation, etc).
- religious practices or cultural values may prevent women caregivers from seeking immunisation services then men health workers.
- significant travel time in bringing children to immunization session sites, posing safety and mobility issues, especially for younger mothers.
- negative attitudes of some health service providers (towards young, poor or vulnerable mothers) discouraging caregivers from return visits to complete the immunisation schedule.

However, uniformity, standardisation and SOPs are missing to set national prioritisation on immunization with a localised approach for local partners. As evident, poor demand leads to low involvement of community for immunization. The need of the hour is to set a resource pool and guidelines for the engagement of local partners leading to effective community outreach.

¹¹ <https://www.sciencedirect.com/science/article/pii/S0277953617300734>

2. STRATEGY (1/2 PAGE - 3 PAGES RECOMMENDED)

UNDP's Experiences and Lessons Learned

To strengthen and re-energize the Universal Immunization Programme and to achieve full immunization coverage for all eligible children and pregnant women, the Ministry of Health and Family Welfare (MoHFW) introduced activities funded through Gavi's Health System Strengthening grants, **HSS-I** (2013-2018) and **HSS-II** (2017-2023).

Under the guidance of the MoHFW, UNDP introduced the **Electronic Vaccine Intelligence Network (eVIN)** during the previous UNDP Country Programme cycles 2013-17 and 2018-22. eVIN supports the management and delivery of vaccines in the right quantity, right quality, at the right time and right temperature, across India. eVIN digitalised the entire vaccine stock management system and strengthened the Universal Immunization Programme of the Government of India by providing real-time information on vaccine stocks and flows, and storage temperatures. At present, eVIN is fully operational across India, covering 100% of districts and all 29,653 vaccine cold chain points. This integrated solution addressed the inequities in vaccine supply by managing constraints of infrastructure, management information systems, and human resources; and addressing the issues of overstocking and stockouts of vaccines. UNDP is transitioning the eVIN expenses from donor funding to funding from the National Health Mission, Government of India.

As per the independent 'Techno-Economic Assessment of eVIN'¹², eVIN has had a significant impact on improving the vaccine delivery system in the initial 12 states. Programme managers can view the entire supply chain from national to last-mile cold chain point level and track vaccine doses and their storage temperature online in real-time. There has been a 72% reduction in vaccine stock-outs across the cold chain points and the average duration for a stockout has reduced from 5 days to 3 days. eVIN has had a significant impact in empowering women vaccine handlers as they got trained and adopted a smarter digital technology to do the daily vaccine stock management at their respective health centres. To ensure this UNDP during the previous HSS phase empowered healthcare workers with smartphones and as recurring support providing data-packs to access the eVIN application. The capacity to access the digital ecosystem has enhanced for more than 30,000 healthcare workers.

As per the independent 'Country Programme Action Plan' outcome evaluation report for UNDP India's programme cycle 2013-17, eVIN represents a good model of integrating the technological system to support a 'systems challenge' in service delivery for last-mile impact. The evaluation report also says that eVIN has had high positive side effects in terms of better record keeping, promotion of accountable and transparent real-time system and use of MIS in decision making¹³.

The eVIN solution was launched during the previous UNDP Country Programme cycles 2013-17 and 2018-22, for the management and delivery of vaccines in the right quantity, right quality, at the right time and right temperature, across all 751 districts of 36 states and union territories (UTs) of India.

During the COVID-19 pandemic, the MoHFW has mandated UNDP to expand the immunization technical assistance to support the world's largest COVID-19 vaccination drive. Under the guidance of MoHFW, UNDP developed the **Co-WIN (Winning Over COVID)** digital platform, with three rounds of funding support from Gavi (i) COVAX Technical Assistance (ii) COVID-19 Vaccine Delivery Support (CDS) - Early Access and (iii) CDS - Need Based and some gap funding from MoHFW. Co-WIN facilitated the planning, implementation, monitoring, and evaluation of the Covid vaccination

¹² eVIN Techno-Economic Assessment –Ministry Of Health And Family Welfare
https://nhm.gov.in/New_Updates_2018/NHM_Components/Immunization/Guidelines_for_immunization/eVIN_Assessment_Report.pdf

¹³ Independent CPAP Outcome Evaluation Report for UNDP India 2013-17

programme in India. It has both citizen and administrator interfaces, it offers a user-friendly simple interface to register and select a convenient facility and real-time dashboards to visualise and disaggregate demographic data on vaccine coverage, consumption, and wastage. As of 31 December 2022, Co-WIN registered 1.1 billion Indians and recorded the administration of 2.2 million vaccine doses within the short span of 20 months and tracked beneficiaries on a real-time basis¹⁴.

As per the ‘Independent Country Programme Evaluation (ICPE)’ of UNDP India’s programme cycle 2018-22¹⁵, in addition to the digital cloud-based platform for real-time visibility of vaccine stocks and consumption patterns, eVIN has systematized the operating procedures to streamline the vaccine supply chain. These, together with the presence of qualified human resources for support and supervision at every district, have been cited by a number of senior government officials as the unique value-adds of eVIN to the vaccine programmes of the country. The women cold-chain handlers associated with eVIN expressed that UNDP training on how to use their smartphones efficiently had helped them do their work more efficiently, connect better with colleagues, and have translated into the improved agency to participate in decision-making and enhanced social status and recognition. It reported that MoHFW has also drawn up plans for the integration of both eVIN and Co-WIN systems, to create unified vaccination management to handle all types of vaccination events. GoI’s intent of working with UNDP to deliver on this ambition reflects the credibility and accomplishments of the team working on eVIN and Co-WIN systems.

Health system strengthening efforts have the ability to impact people’s lives and futures. The eVIN and Co-WIN platforms emerged as powerful examples of how digital technology can expand public health programmes

Current Strategy

As per India’s national full immunization coverage (FIC) strategy, the country aims to achieve universal immunisation coverage. Besides, India aims to reduce the number of zero-dose children by at least 30% from 1.4 million in 2019 (WUENIC 2019)¹⁶ to meet the goals of UN Sustainable Development Framework’s Immunization Agenda 2030 (IA2030)¹⁷. This aligns with the Gavi’s strategy 5.0 (for 2021–2025)¹⁸, with a vision of “Leaving no one behind with immunisation” and a mission to save lives and protect people’s health by increasing the equitable and sustainable use of vaccines.

To strengthen the immunization programme in India, the project’s strategy is to (i) increase equitable access to vaccines and leave no one behind across India, addressing gender as well as socio-economic barriers, (ii) strengthen the review mechanism and immunization data analytics; and (iii) strengthen systems for streamlining and monitoring ‘Social and Behaviour Change Communication’ efforts in specific subnational geographies with high proportion of zero-dose children.

● Increase access to vaccines

Monitoring vaccine logistics management system: under the HSS II project, UNDP will continue to support the eVIN Solution, which is specifically focused on vaccine logistics management. The focus will be to support the eVIN software platform, build the capacity of government data managers on eVIN dashboards, data analysis and inform programmatic decisions and sustain its efforts to institutionalise eVIN in all the states and UTs through signed agreements for government financing.

¹⁴ <https://dashboard.cowin.gov.in/>

¹⁵ <https://erc.undp.org/evaluation/documents/download/21433>

¹⁶ <https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicf-estimates-of-national-immunization-coverage>

¹⁷ <https://www.who.int/publications/m/item/progress-and-challenges-with-achieving-universal-immunization-coverage>

¹⁸ <https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025>

So far, UNDP has supported 26 (out of 36 states and UTs) to successfully transition the eVIN expenses from donor funding to funding from the State National Health Mission. These states started providing funds to UNDP for technical support for continuous monitoring and support of eVIN, through MOA/LOE Route. Now the effort is to sustain and routinely renew these MOA/LOE and do strong advocacy with the remaining 10 states and UTs to sign MOA/LOE with UNDP and provide regular funds from all the state health departments. The HSS II project is closely linked to the interventions under HSS III. Although the interventions differ, they remain closely interconnected and collectively contribute to the overall goals of the projects.

Developing and implementing an immunization beneficiary management system: The MoHFW looks forward to repurposing the Co-WIN technology for various healthcare cases. Co-WIN is currently being repurposed for offering all the routine immunisation (RI) services under the Universal Immunization Programme (UIP) of the Government of India. With Co-WIN implementation, it is now possible to digitize data on vaccination beneficiaries, and plan sessions systematically along with large databases and analytics. This provides a huge potential to bring an integrated eVIN/Co-WIN platform in RI and track vaccine consumption along with UIP beneficiaries in one place with an overarching objective of reducing the number of zero-dose and partially immunized children and improving immunization coverage. MoHFW has mandated UNDP to develop and implement a new digital innovation, termed U-WIN, as the Electronic Immunization Registry for the Universal Immunization Program. The purpose of this IT platform is to register every pregnant woman, capture the delivery outcome, newborn birth registration and vaccination events. U-WIN will be developed as an easy and user-friendly platform, which can be used in low-resource settings by female health workers with varying skill sets. U-WIN is developed to capture all immunization and childbirth events across the public and private sectors. There are funds allocated for the empowerment of private sector data managers on U-WIN

U-WIN will be designed and developed as per National digital health policy and will be in compliance with ABDM (Ayushman Bharat Digital Health Mission). U-WIN will enable ABHA (Ayushman Bharat Health Account) ID creation. U-WIN will be integrated to RCH Portal, Poshan Tracker, eVIN and other application of Ministry of Health and Family Welfare and Ministry of Women and Child to avoid data duplication and data redundancy to empower healthcare workers.

Strengthen review mechanism and data analytics: Use of existing data for corrective action is envisioned through triangulation and validation of data from various sources. Existing data sources such as HMIS, UWIN, eVIN, NCCMIS, SafeVAC, BeSD, Monitoring and Mentorship (M&M), NFHS and other surveys will be used to synthesize information and take programmatic action.

The data analytics intervention plans to support the decision-makers at the district level to make informed decisions by understanding the gaps in the program implementation. Enhanced data use for reviewing and undertaking corrective measures in the RI programs of the targeted districts will further add value to the monitoring process of the zero-dose cohorts and missing communities.

The intervention to strengthen data analytics and robustness of the review mechanism will not only be restricted to the 143 high-impact districts but also strengthen the capacities of national and sub-national staff to equip them to use data for action.

- **Institutionalise engagement of local partners for community mobilisation**

The Ministry of Health and Family Welfare has a strong and intentional focus on demand generation for vaccination services including addressing gender and inclusion related barriers and gaps and social and behavioural change, and they look forward to setting and operationalizing an inter-connected and comprehensive ecosystem on demand and CSO engagement geared towards impact, systems strengthening, equitable access and distribution for marginalised communities, multi-sectoral convergence and sustainability, with a clear and strong connection with the overall governance and delivery mechanism.

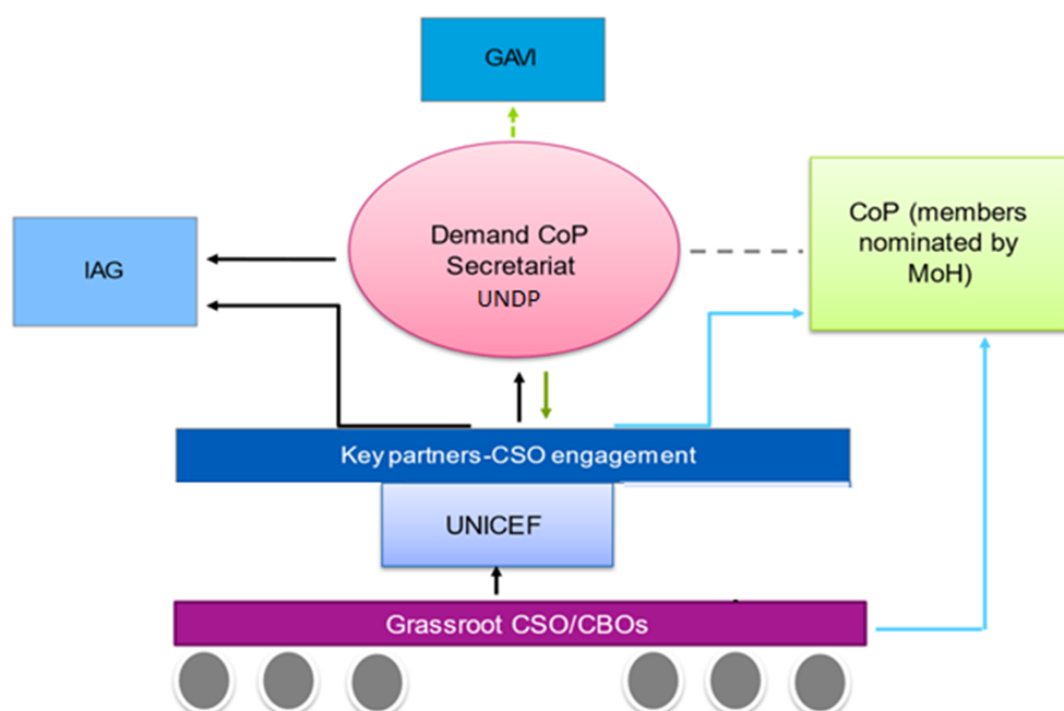
To facilitate this, UNDP will set up a ‘Community of Practice on Demand Generation (CoP-Demand)’ to steer the demand for immunization and boost the community mobilization agenda. The CoPD will play an advisory role in ensuring the alignment of the social mobilization strategy to the community’s needs and perceptions and, effective implementation of the communication and social mobilization activities. It will also guide the activities of CSOs which will be engaged at the grassroots level for ensuring institutionalizing the of social mobilization activities. The structure of CoP-Demand is envisaged as the think tank for demand activities and will guide the communication policy of UIP. The CoP- Demand will be guided by a stakeholder-validated gender and inclusion strategy.

As the country continues with the efforts of reaching the missed-out and dropped-out children and pregnant women through RI intensification drives, this strategy is focused on unreached children, pregnant women and communities who due to gaps in supply or demand stay disconnected from the health system, not only for immunization but also for other critical services like nutrition etc.

The intervention to strengthen data analytics and robustness of the review mechanism will not only be restricted to the 143 high-impact districts but also strengthen the capacities of national and sub-national staff to equip them to use data for action.

COP-D will establish a secretariat which will work under the guidance of the Technical Advisory group constituted by the Ministry of Health and Family Welfare. The Secretariat will coordinate with UNICEF for CSOs engagement and establish a review mechanism. COP-D structure will include subject matter expert, behaviour change specialist, M&E specialists, communication specialists along with operations staff to manage finance and admin.

Vision on the Demand CoP -CSO –ecosystem functioning



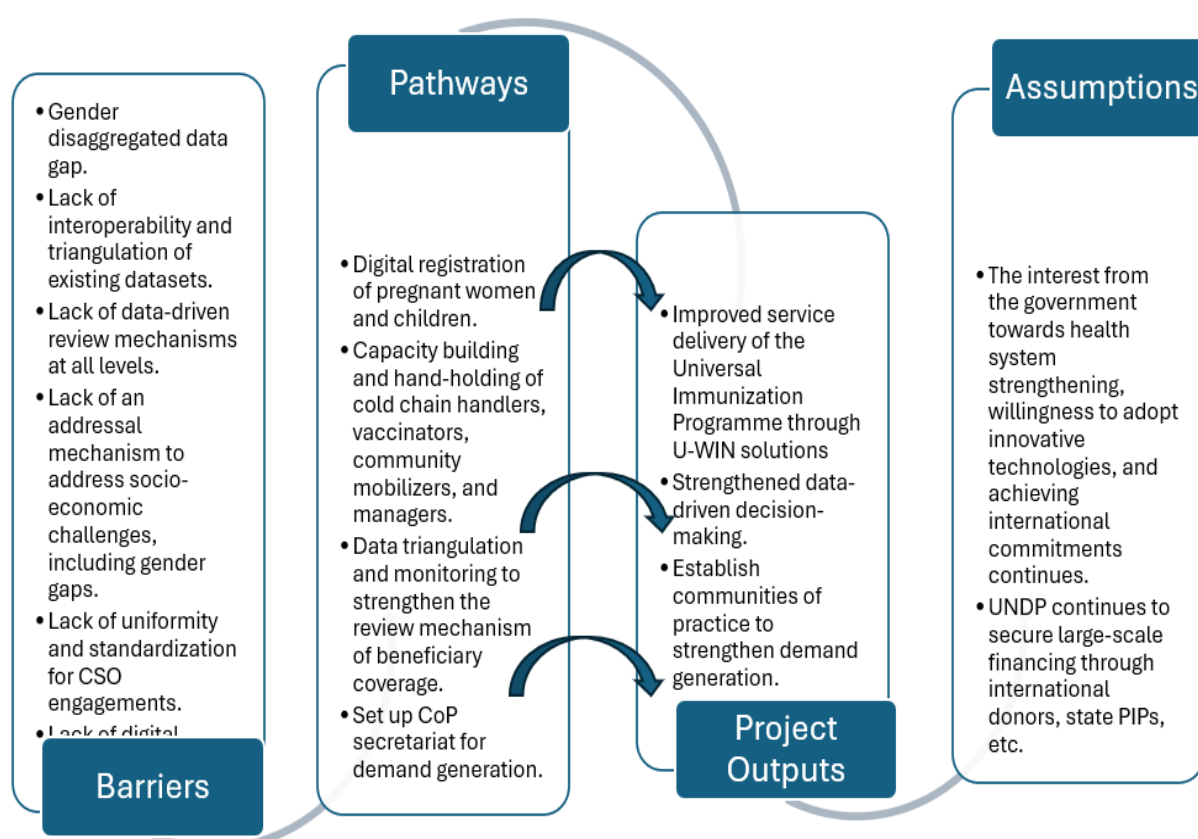
Theory of Change (ToC)

The theory of change (TOC) that guides the logic for the results is:

if an inclusive and scalable innovative, digital immunization supply chain and beneficiary management interventions are implemented and data-driven decision-making for public service delivery are promoted and **if** capacities of health care service providers and local partners are strengthened **then** equitable access and efficiency of India's vaccination services will be further enhanced which is critical for the acceleration of SDG realisation.

Assumptions

- The interest from the government towards health system strengthening, willingness to adopt innovative technologies and achieving international commitments continues.
- UNDP continues to secure large-scale financing through international donors, state PIPs, etc.



3. RESULTS AND PARTNERSHIPS

Expected Results

The project is focused on improving the efficiency of the vaccination system in India to achieve universal immunisation coverage, leaving no one behind by bridging access disparity among women and girls.

The previous section discussed project strategies to (i) increase access to vaccines and (ii) institutionalise engagement of local partners for community mobilisation. To execute these strategies, the project implementation is clustered around three significant outputs, the first two outputs are for the first strategy and the third output is for the second strategy. The description and activities of each of the outputs are provided below:

Project Output 1: Improved service delivery of the Universal Immunization Programme

Description: Under the guidance of MoHFW, UNDP will repurpose the Co-WIN technology for all the Routine Immunisation (RI) services. UNDP will develop and implement U-WIN, to register every pregnant woman, capture the delivery outcome, newborn birth registration and vaccination events. U-WIN will establish a name-based immunization registry and support in tracking beneficiaries for immunization services and identifying zero-dose/dropout children.

This effort will be funded through the third phase of Gavi's Health System Strengthening (HSS-III) grant (2023-2026).

Activities for Output 1

Capacity Building:

- Building capacity of the UNDP team (Project team and U-WIN coordinators) on U-WIN rollout and monitoring of U-WIN data quality, analyses and reporting.
- Building capacity of the healthcare workers to access digital applications (ANMs and ASHAs): The capacities of more than one million women healthcare workers will be enhanced to access and use digital applications including U-WIN for reporting and tracking vaccination. The application will also provision channelization to existing social helplines by the Government of India includes the helpline for domestic violence and sexual abuse. Similar job aides will also be incorporated in the app.
- Building capacity of data managers, Block Officials, District Immunization Officers, and State Immunization Officers for utilising U-WIN for routine data review and making data-driven decisions

Provide goods and services for:

- Development, maintenance, upgradation, and hosting for U-WIN
- Engagement of U-WIN national/regional staff, U-WIN coordinators and setting up Project management Unit (PMU)
- Development of a digital monitoring system for robust internal monitoring
- Design of communication and advocacy materials on U-WIN

Project Output 2: Strengthen Review Mechanism and Immunisation Data Analytics

Description : Under "Data Analytics and Review" project aims to achieve objective and outcomes, structured into 2 key components.

Component 1 – Strengthen and institutionalize capacity of program managers for real-time programme monitoring and review data to take prompt action for reaching zero-dose children and improving Routine Immunization coverage

Component 2 – Strengthening Governance, Management, data quality/analytics and Review Systems for Immunisation planning and review at national level and Strengthening Review Systems for reducing Zero-dose children and improving routine immunisation coverage at State, District and Block level.

Activities for Output 2

Provide goods and services for:

- Anchor stakeholder consultations for the landscape analysis of current digital solutions operational for routine immunization, understanding critical indicators and scoping of technical feasibility for the integrated dashboard.
- Strengthening of data quality, triangulation, analysis and review system to improve vaccination coverage.

Project Output 3: Establish communities of practice secretariat on demand generation (CoP-Demand)

UNDP will set up a ‘Community of Practice on Demand Generation (CoP-Demand)’ Secretariat to support MoHFW and partners with experience in public health and specifically in immunisation programmes in a holistic way, along with experience gender/LNOB, in social & digital marketing, research, behaviour change and monitoring, learning & evaluation. This would be a catalytic element in the entire system, geared towards shifting away from the usual traditional approaches to demand generation. The CoP secretariat will provide technical leadership, operational guidance and coordination within the entire ecosystem, reporting to IAG, MoHFW and Gavi.

The CoP secretariat will anchor the Community of Practice on Demand (CoP- Demand) which is envisioned as a group of nominated technical, inclusion and immunization experts, and will also include CSO representatives involved in working with women and children, community engagement, other departments etc. The CoP- Demand will inform appropriate and context-specific program design and interventions for demand in different geographies and sub-population based on the behavioural and accessibility insights of the barriers driven from systematic desk review data and formative research studies (both qualitative and quantitative information in selected regions and cohorts of the project-districts) and establish a human-centred design (HCD) approach keeping in view the aspect of the continuum of care. The overarching approach of CoP-Demand will be to guide the development of demand strategy and ensure coordinated implementation of all demand-related interventions.

The CoP secretariat will bring in the latest social, economic and behavioural change thinking, using an evidence-based approach to design interventions, the impact of which will be measured by an independent evaluator. The CoP secretariat will also drive a strong learning and monitoring agenda and drive inter-sectoral linkages through the entire development phase.

The CoP secretariat will also lead on proof-of-concept pilots and utilize social data in selected places which can test and inform interventions for addressing gender disparities and mainstreaming gender with immunization, tailored to undertake gender-responsive approaches in the project. The CoP-Demand will be informed by a gender and inclusion strategy developed by the CoP secretariat and validated by partners/stakeholders. The purpose of this strategy will be to enable gender responsive health service delivery system.

The CoP secretariat will introduce a robust monitoring system through IT-based support to keep the implementing partners and CSO constantly informed about the progress, bottlenecks, gaps, and immediate course correction requirements. UNICEF will partner together across the geographies under the technical leadership and directives of the CoP secretariat, to steer this massive shift.

The CoP secretariat will strengthen the accountability and governance framework. It will keep track of the timely conducted all the state and district task force meetings for immunization (STFI / DTFI) to enhance involvement and accountability/ownership of state and district administrative and health officials.

Activities for Output 3

Provide goods and services for:

- Supporting the development of demand strategy and coordinating the implementation of all demand-related interventions, including women rights organizations, civil society organizations (CSO) working with women and children and their engagement.
- Conducting behavioural insight (BI) studies
- Undertaking human-centred and gender responsive design pilots
- Introducing a robust monitoring system through IT-based support to keep the implementing partners and CSO constantly informed about the progress, bottlenecks, gaps, and immediate course correction requirements.

Resources Required to Achieve the Expected Results

U-WIN, Data Analytics and CoP-Demand: MoHFW has budgeted expenses for three interventions (U-WIN, Data analytics and CoP-Demand) under the upcoming grant, the third phase of Gavi's Health System Strengthening (HSS-III), 2023-2026.

Partnerships

The Immunization Division of MoHFW has created a consortium of partners from various backgrounds and expertise who have the ability to implement, monitor and produce the desired outcome of the immunization programme. These include partners from (i) UN organizations - UNICEF, UNDP, WHO, (ii) international NGOs - JHPEIGO, John Snow Institute, Clinton Health Access Initiative, INCLIN, GHS, (iii) ITSU (Immunization Technical Support Unit), NCCVMRC (iv) CSOs, private health sector, community organizations and networks, and (v) donors - Bill and Melinda Gates Foundation, USAID, World-Bank and Gavi. These partners and institutions work closely by mutually agreeing on goals, objectives, and states' selection while contributing to the zero-dose implementation plan. With robust techno-managerial leadership from the central government, passion, commitment, and respect for all the other partners cemented the partnership landscape. Project will establish synergies between the partner agencies through Immunization Action Group (IAG) under the scope of MEL (Monitoring, Evaluation and Learning) framework.

The One-UN coordination framework on health is a network of all UN country health teams. It is a review forum where all the teams meet once every two months and define their main activities in health. Together as One-UN UNICEF, WHO and UNDP help the Government of India to provide end-to-end support for routine immunization. The cold-chain system and community mobilization are strengthened by UNICEF. WHO supports VPD surveillance, micro-planning and cluster containment strategies to halt the spread of disease. UNDP supports the development of digital health platforms (eVIN, Co-WIN and going ahead U-WIN). Support from other organizations are also available in building capacities of human resource development, data triangulation and validation, IT-enabled monitoring and evaluation system and utilizing social data analysis in designing interventions for enhancing community demand.

Risks and Assumptions

Risk: The interventions on ensuring the sustainability of the U-WIN may not be executed considering the timeline of the project.

Mitigation Strategy: UNDP will liaise with the Government at the national and state levels to ensure the smooth institutionalisation of project interventions.

Assumption: UNDP is able to institutionalise U-WIN at the national and state levels with support from the Government.

Risk: Recommendations and learnings from pilots, research and studies conducted by COP-D are not adapted/utilized by CSOs and frontline workers

Mitigation strategy: Periodic review of CSOs to ensure that recommendations from COP-D are incorporated.

Assumptions: UNDP will set up mechanisms to review CSOs work on a periodic basis.

Risk: Challenges in the triangulation of data from different sources to generate action points during meetings on Routine immunization may hamper the achievement of desired objectives.

Mitigation strategy: Data triangulation tools to be provisioned which are to be utilized in RI Review meetings at all levels.

Assumptions: UNDP will provision data triangulation tools and further strengthen the review meetings mechanism for Routine immunization.

Risk: Delay in funds disbursement by state governments may hamper the effective implementation of project activities funded through states.

Mitigation strategy: Regular meetings and follow-ups with the state to ensure timely disbursement of funds.

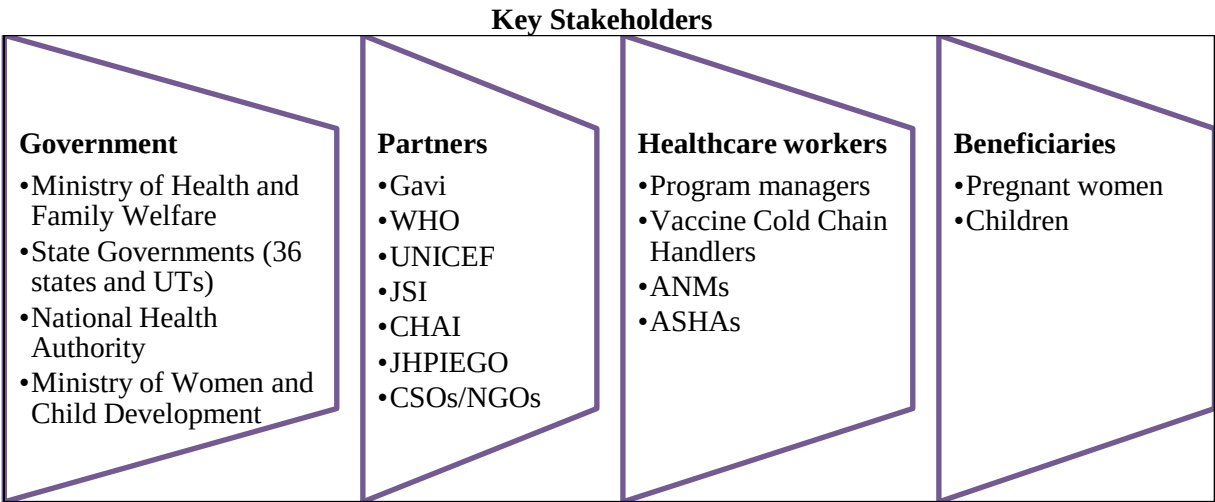
Assumptions: States are more responsive to timely disbursement of funds upon submission of SOEs and UCs.

Stakeholder Engagement

The primary stakeholder in the project is the Immunisation Division of MoHFW and state health departments. The project will be implemented in close collaboration and consultation with them.

All the key stakeholders will be engaged during the implementation, monitoring and evaluation of the project. Gavi, NITI Aayog and the Department of Economic Affairs, Ministry of Finance, will be engaged and updated on a regular basis on the progress of the project and achievement of the project milestones and results.

The target beneficiaries along with the vaccine managers, vaccinators and community mobilisers will be engaged and empowered to deliver efficient and effective healthcare services at their workplace. As an outcome of the project, citizens of India will have improved access to affordable essential vaccines for all. Through the communication channels, the project will spread awareness about the intervention.



South-South and Triangular Cooperation (SSC/TrC)

UNDP along with the Ministry of Health and Family Welfare aims to expand eVIN, Co-WIN and U-WIN with other countries in developing digital health innovation for a wider range of health commodities and services. The investment can be leveraged with donors like Global Fund and GAVI for a longer-term partnership with UNDP. UNDP India will promote cross-learning and lessons learnt with other countries and help UNDP country offices in customizing digital solutions for their own context.

During the G20 presidency, India has been showcasing eVIN, CoWIN and U-WIN as digital health innovations and digital public infrastructure that works for millions of people, improving the efficiency and quality of health care. India has already indicated its intent to offer such technologies to interested countries. With these aspects, eVIN, CoWIN and U-WIN are developed as open-source solutions keeping sustainability and exit strategy in mind.

Digital Solutions¹⁹

This programme is based on the use of digital technology to strengthen and expand public health programmes in India. Key interventions include investment in People, processes and Technology. Wherein a mobile application will be developed for over 1 million healthcare workers and a dashboard and reports module for programme managers.

For more than 1 million female healthcare workers, this project will enhance the capacity of female healthcare workers to access the digital ecosystem.

The digital solution will be responsibly developed to ensure that it can be utilized by female healthcare workers with varying skill sets and can work in low-resource environments.

Knowledge

An integral part of the project is knowledge management, training, and communications. The programme aims to (i) develop instructional videos, easy reference materials or instruction manuals for the healthcare worker, the end user government staff, (ii) create state and national factsheets/dashboards with government programme managers and (iii) circulate brochures and posters for advocacy and to share the learnings generated by the project and to explore its potential for expansion in all service delivery and supply chain aspects of health system strengthening. There will be active media engagement to garner interest and increase awareness about the programme. Data generated from U-WIN will be eventually utilized to understand critical indicators like full immunization coverage, dropouts, left-outs, etc. These indicators will be utilized as knowledge products to understand health and accessibility scenarios by various groups.

For demand generation as well as strengthening supply, multiple research, studies and pilots will be conducted during the course of the project. Findings and recommendations of these interventions are expected to be adopted by CSOs/NGOs frontline workers and policymakers.

Further, knowledge products and communication tools will be developed for enhancing demand as well as strengthening supply. These will include 1-2 nationwide campaigns, digital as well as static communication products and behaviour tools for consumption by CSOs, State Government, FLWs and other frontline stakeholders, modules for digital and social media use, and four reviews and/or publications in English language no older than 10 years (from 2022) from sources including Cochrane, Google Scholar, pan-India publications to be included in review. Adaptations of creatives and communication assets will also be reproduced in vernacular languages across the focal states in 10 languages.

Sustainability and Scaling Up

The success of eVIN and Co-WIN implementation has led to the central and state governments recognizing the added value of UNDP as an important developmental partner in the health sector. MoHFW has agreed to sustain eVIN across 36 states and UTs. UNDP has used a blended financing model, utilising funds from GAVI Alliance for the eVIN scale-up, and from various state governments' cost-sharing for sustaining it.

The sustainability of these interventions is ensured by harnessing and strengthening the flagship national programmes, leveraging government partnerships and dovetailing the UN system's intervention with government schemes and programmes.

¹⁹ Please see the [Guideline “Embedding Digital in Project Design”](#).

U-WIN is being developed as an open-source solution and to be utilized as Digital public good. UNDP to ensure that ownership of data and solutions remains with the Ministry of Health and Family Welfare since the inception of the project. This includes the data infrastructure ownership with the Government, intellectual property rights and technical documentation. As part of its exit strategy, knowledge transfer and documentation will be ensured by UNDP.

4. PROJECT MANAGEMENT (1/2 PAGES – 2 PAGES RECOMMENDED)

Cost Efficiency and Effectiveness

To ensure cost efficiency, the project team will collaborate with other teams, Government and UN Agencies. For instance, to optimize the procurement process, long-term agreements with existing UN Agencies and country offices will be utilized. Project monitoring and surveillance to be jointly done by Central Government, State Government and other UN agencies like WHO and UNICEF. To ensure the triangulation of data, project team will collaborate with multiple agencies to a prepare dashboard and report for data driven decision making and further strengthen review mechanism. The project has been using portfolio management approach wherein several initiatives and partnerships with various stakeholders have been converged to ensure synergies and reduce transaction cost.

Project Management

The project will be implemented at the National, State and District Levels. Project Management Units will be established at each level which will primarily work in close coordination with the Immunization Division, Ministry of Health and Family Welfare, State Routine Immunisation Cell and District Immunization officers to monitor the implementation of the programme.

The project will be directly implemented by UNDP in cooperation with the respective Central and State Governments. UNDP will be responsible for all financial management, reporting, procurement, and recruitment services for which UNDP recruitment and procurement rules and regulations will apply. A Project Coordinator will be appointed for the implementation of the programme, who will be supported by a team of technical and operation experts at the national and state levels.

Financial flow and financial management:

The project will be implemented by UNDP under the Direct Implementation modality. In this case, UNDP assumes the responsibility for mobilizing and effectively applying the required inputs to reach the expected outputs. UNDP assumes overall management responsibility and accountability for project implementation. Accordingly, UNDP would follow all policies and procedures established for its own operations and will be responsible for all financial management, reporting, procurement, and recruitment services.

UNDP may identify Responsible Parties to carry out activities within a Direct Implementation Modality (DIM) project. A Responsible Party is defined as an entity that has been selected to act on behalf of UNDP based on a written agreement or contract to purchase goods or provide services using the project budget.

For this project, the Country Office India prefers to engage NGOs, CSOs, or non-profits over commercial market players due to several critical factors.

These include the need for sensitive data confidentiality, as the government is cautious about sharing critical data with commercial entities. The CSOs and CBOs, already working with the government, are trusted to manage this data responsibly. Additionally, CSOs have proven relevant expertise in government health initiatives, such as Routine Immunization. In contrast, commercial agencies may lack this sector-specific knowledge, requiring additional resources for training, which could strain the

project budget. Budget allocations for data analytics and review, as determined by donors and the MoHFW, are based on previous projects undertaken by CSOs and similar agencies. The costs associated with hiring commercial entities are comparatively higher and could exceed the budget. Further, the government's multiyear Program Implementation Plan (PIP) includes provisions for engaging external CSOs and CBOs for data analytics work. Considering this background, involving NGOs, CSOs, or CBOs is envisaged as a strategic approach to ensure effective and efficient project implementation.

All Responsible Parties are directly accountable to UNDP in accordance with the terms of their agreement or contract with UNDP. The Responsible Party may follow its own procedures only to the extent that they do not contravene the principles of the Financial Regulations and Rules of UNDP. Where the financial governance of the responsible party, does not provide the required guidance to ensure best value for money, fairness, integrity, transparency, and effective international competition, then UNDP rules and regulations shall apply.

In accordance with the decisions, policies and procedures of UNDP's Executive Board reflected in its Policy on Cost Recovery from Other Resources, the Contribution shall be subject to cost recovery for indirect costs incurred by UNDP structures in providing General Management Support (GMS) services.

Under the Government financing component, the UNDP Country Office in New Delhi, through its Programme, Procurement, Human Resource and Finance teams will provide transactional support, oversight, development effectiveness and quality assurance of the services being provided and will charge management fee of 3% on the gross expenditures against funds received to cover such direct and indirect support service costs of the project.

Project Audit: The DIM project will be audited as per UNDP rules and regulations.

Funding from Donors/Funding agencies: The donor funds shall be subject exclusively to the internal and external auditing procedures provided for in the financial regulations, rules, policies, and procedures of UNDP. Should the annual Audit Report of the UN Board of Auditors to its governing body contain observations relevant to the donor funds, such information shall be made available to the donor by the country office.

Project Closure: The project would be closed as per UNDP Rules and Regulations.

5. RESULTS FRAMEWORK

Intended Outcome as stated in the UN Sustainable Development Cooperation Framework (UNSDCF) (2023-2027), India: Programme Results and Resource Framework

Outcome 1: Quality health care and positive health practices for all
Output 1.1: Inclusive and high-quality health systems: Increased government capacity to make public health systems inclusive and of high quality.
Intervention areas: Strengthening systems for resilience and providing quality primary healthcare.
Result: By 2027, communities, especially the most disadvantaged, demand for and benefit from an inclusive, universal, affordable, accessible, accountable, and quality health care services, while adopting positive health practices.
Indicator: Percentage of children (aged 12–23 months) fully immunized
Baseline (2022): Girls– 61.9% Boys– 62.1% Total– 76.4% Target (2027): 90.0%; Source: NFHS and government reports.

Outcome indicators as stated in the UNDP Country Programme Document (CPD) (2023–2027) Results and Resources Framework:

Output 1.2: Improved service delivery of health care and development programmes to the last mile to ensure that no one is left behind.
Indicator 1.2.1: Number of states that institutionalized the strengthened systems for health and development programmes for equitable access to services.
Baseline (2022): 0 Target (2027): 36 States and UTs; Source: Ministry of Health & Family Welfare, U-WIN Dashboards
Indicator 1.2.3: Number of people that benefited from the strengthened systems on health and development programmes.
Baseline (2022): 0 Target (2027): 150 million; Source: Ministry of Health & Family Welfare, U-WIN Dashboards

Applicable Output(s) from the UNDP Strategic Plan

Signature Solution 1: Poverty and Inequality

Result 1.4: Equitable, resilient and sustainable systems for health and pandemic preparedness strengthened to address communicable and non-communicable diseases, including COVID-19, HIV, tuberculosis, malaria and mental health.
Indicator 1.4.2 a: Number of countries, which introduced digital solutions for vaccine delivery and health systems strengthening.
Indicator 1.4.2 b: Number of countries, which deployed hyperlocal vaccine data analytics for decision making and equitable and inclusive responses.

Signature Solution 2: Governance

Result 2.3: Responsive governance systems and local governance strengthened for socio economic opportunity, inclusive basic service delivery, community security, and peacebuilding.
Indicator 2.3.1 a: Number of national institutions with strengthened public administration and core government functions for Improved service delivery.

Intended Sustainable Development Goal (SDG) 2030 Agenda	
Goal#3:	Ensure healthy lives and promote well-being for all at all ages.
Target 3.8:	Universal health coverage - By 2030, achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all .
Indicator 3.8.1:	Coverage of essential health services
Target 3.b:	Support the research and development of vaccines and medicines for the communicable and non- communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines , in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all .
Indicator 3.b.1:	% target population covered by all vaccines included in the national programme.
Project title and Quantum Project Number: Improving the efficiency of the vaccination system in India; 01001150	

Expected Outputs	Output Indicators	Data Source	Baseline		Targets				Frequency of data collection	Data Collection Methods & Risks
			Value	Year	Year 1 2023	Year 2 2024	Year 3 2025	Year 4 2026		
Output 1: Improved service delivery of the Universal Immunization Programme GEN Marker: GEN 2 \\	1.1 # of states maintain U-WIN user adherence rate >90% ²⁰	U-WIN Dashboard	0	2022	36	36	36	36	Quarterly	U-WIN application aggregated to U-WIN dashboard. Data generated during review meetings. Risk: Low adherence rate for U-WIN application.
	1.2 # of children (Boys and Girls) vaccinated through U-WIN		0	202	1 million	2 million	3 million	3 million	Quarterly	
	1.3 # of pregnant women vaccinated through U-WIN		0	2023	1 million	2 million	2 million	2 million	Quarterly	
	1.4 Capacities of women healthcare workers built on usage U-WIN application.		0	2023	0.5 million	1 million	1 million	1 million	Quarterly	
Output 2: Strengthen Review Mechanism and Immunisation Data Analytics GEN Marker: GEN 1	2.1 # of data sources triangulated to derive immunisation decisions at the state and national level	Data Analytics Dashboard	0	2022	3	6	10	14	Quarterly	Data generated during review meetings.
	2.2 Monthly conduction of state/district task force meetings by # of states/districts	COP Dashboard	TBD	2022	143	143	143	143	Monthly	Risk: Low number of review meeting.
Output 3: Establish communities of practice secretariat on demand generation (CoP-Demand)	3.1.# of CoP-demand secretariat setup and operationalized driven by socio-economic inclusion and gender-responsive strategy	COP Dashboard	0	2022	0	1	1	1	Yearly	Data generated during review meetings of CSOs.
	3.2.Number of review meetings conducted by the CoP-demand Secretariat with government and partners ²¹		0	2022	1	5	9	13	Quarterly	Risk: Insufficient reports by CSOs on adoption practices

²⁰ % of vaccinators and mobilisers conducting transactions through U-WIN

²¹ To review the efficiency of CSO engagement by relevant partners on community mobilization to capture zero-dose children

Expected Outputs	Output Indicators	Data Source	Baseline		Targets				Frequency of data collection	Data Collection Methods & Risks
			Value	Year	Year 1 2023	Year 2 2024	Year 3 2025	Year 4 2026		
GEN Marker: GEN 2	3.3. Number of technical/ research studies completed, focusing on innovation, inclusion, gender-related barriers and community mobilization		0	2022	0	3	3	5	Quarterly	recommended by COP-D

6. MONITORING AND EVALUATION

Monitoring Plan

Monitoring Activity	Purpose	Frequency	Expected Action	Partners (if joint)	Cost (if any)
Track results progress	Progress data against the results indicators in the RRF, including gender results, will be collected and analysed to assess the progress of the project in achieving the agreed outputs.	Quarterly	Slower than expected progress will be addressed by project management.	NA	\$1,497,600
Monitor and Manage Risk	Identify specific risks that may threaten the achievement of intended results. Identify and monitor risk management actions using a risk log. This includes monitoring measures and plans that may have been required as per UNDP's Social and Environmental Standards. Audits will be conducted in accordance with UNDP's audit policy to manage financial risk, includes CoP-D, U-WIN and Data Triangulation.	Quarterly	Risks are identified by project management and actions are taken to manage risk. The risk log is actively maintained to keep track of identified risks and actions taken.	NA	\$580,000
Learn	Knowledge, good practices and lessons covering stories from most vulnerable groups including women will be captured regularly, as well as actively sourced from other projects and partners and integrated back into the project.	Annually	Relevant lessons are captured by the project team and used to inform management decisions.	NA	\$300,000
Annual Project Quality Assurance	The quality of the project will be assessed against UNDP's quality standards to identify project strengths and weaknesses and to inform management decision-making to improve the project.	Annually	Areas of strength and weakness will be reviewed by project management and used to inform decisions to improve project performance.	NA	NA
Review and Make Course Corrections	Internal review of data and evidence from all monitoring actions to inform decision-making.	At least annually	Performance data, risks, lessons and quality will be discussed by the project board and used to make course corrections.	NA	\$374,400
Project Report	A progress report will be presented to the Project Board and key stakeholders, consisting of progress data showing the results	Annually		NA	\$9,000

Monitoring Activity	Purpose	Frequency	Expected Action	Partners (if joint)	Cost (if any)
	achieved against pre-defined annual targets at the output level, the annual project quality rating summary, an updated risk long with mitigation measures, and any evaluation or review reports prepared over the period.				
Project Review (Project Board)	The project's governance mechanism (i.e., project board) will hold regular project reviews to assess the performance of the project and review the Multi-Year Work Plan to ensure realistic budgeting over the life of the project. In the project's final year, the Project Board shall hold an end-of-project review to capture lessons learned and discuss opportunities for scaling up and to socialize project results and lessons learned with relevant audiences.	Bi-annually	Any quality concerns or slower than expected progress should be discussed by the project board and management actions agreed to address the issues identified.	WHO UNICEF	NA

Evaluation Plan

Evaluation Title	Partners (if joint)	Related Strategic Plan Output	UNSDCF/CPD Outcome	Planned Completion Date	Key Evaluation Stakeholders	Cost and Source of Funding
Baseline (eVIN, CoWIN, U-WIN)	UNICEF & WHO	Output 1.2: Improved service delivery of health care and development programmes to the last mile to ensure that no one is left behind	Outcome 1: By 2027, communities, especially the most disadvantaged, demand for and benefit from inclusive, universal, affordable, accessible, accountable, and quality healthcare services, while adopting positive health practices	December 2024	MoHFW	\$601,646
End Line Evaluation (eVIN, CoWIN, U-WIN)				December 2026		\$601,646

7. MULTI-YEAR WORK PLAN^{22, 23}

Expected Outputs	Planned Activities	Planned Budget by Year				Responsible Party	Account Code	Planned Budget	
		2023	2024	2025	2026			Funding Source	Amount (USD)
Output 1: 1 Improved service delivery of the Universal Immunization Programme <i>Gender marker: Gen 2</i>	1.1 UWIN Capacity Building - Training of trainers and users - Capacity building of data managers, DIOs, and SIOs on routine data review	\$ 71,280	\$216,000	\$216,000	\$144,720	UNDP	72100/75700/64300/74500	GAVI	\$648,000
	1.2 UWIN Training Material Communication Materials and Publications	\$11,880	\$36,000	\$36,000	\$24,120	UNDP	72500/74100	GAVI	\$108,000
	1.3 U-WIN Technical & operational assistance - Setup Project Management Unit for UWIN field implementation - Identify strategies for capturing zero-dose children	\$451,139	\$1,367,088	\$1,367,088	\$915,949	UNDP	72100/64300/74500	GAVI	\$4,101,264
	1.4 Secretariat support for GAVI grants	\$39,600	\$120,000	\$120,000	\$ 80,400	UNDP	72100	GAVI	\$360,000
	1.5 Develop, rollout and maintain UWIN software - Identifying agency for U-WIN Hosting, Development and Maintenance	\$1,762,200	\$5,340,000	\$5,340,000	\$3,577,800	UNDP	72100/64300/74500	GAVI	\$16,020,000
	1.6 UWIN Field Implementation - Setup UWIN field team - Rollout UWIN in 100% districts of India	\$1,564,200	\$4,740,000	\$4,740,000	\$3,175,800	UNDP	72100/64300/74500	GAVI	\$14,220,000
	1.7 Support to preparation of NIS (National Immunization Strategy)		\$49,359	-	-	UNDP	72100	GAVI	\$49,359
	1.8 Mid-term and Terminal evaluation of Co-WIN and U-WIN		\$1,20,3292	-	-	UNDP	72100/64300/74500	GAVI	\$1,203,292
									\$ 36,709,915
Output 2: Strengthen Review Mechanism and Immunisation	2.1 Engagement of external agency for data analytics, data triangulation and strengthening review mechanism	\$ 1,75,460	\$37,51,612	\$ 33,13,677	\$ 40,35,130	UNDP	72100/64300/74500	GAVI	\$ 11,275,879
	2.2 Technical support for data review	\$ 27,752	\$ 99,696	\$ 1,04,196	\$ 1,04,196	UNDP	72100/64300/74500	GAVI	\$ 3,35,840

²² Cost definitions and classifications for programme and development effectiveness costs to be charged to the project are defined in the Executive Board decision DP/2010/32

²³ Changes to a project budget affecting the scope (outputs), completion date, or total estimated project costs require a formal budget revision that must be signed by the project board. In other cases, the UNDP programme manager alone may sign the revision provided the other signatories have no objection. This procedure may be applied for example when the purpose of the revision is only to re-phase activities over years.

Data Analytics									
		\$ 11,611,719							
General Management Support (Output 2)	UNDP Program Support Cost@ 8%	\$ 328,281	\$1,353,844	\$ 1,218,957	\$ 964,649	UNDP	75100	GAVI	\$ 3,865,731
TOTAL	\$52,187,365								

Output 3: Establish communities of practice secretariat on demand generation (CoP-Demand) GEN Marker: GEN 2	3.1. Establishment of centre of excellence /secretariat Human resource, Travel, Workshop, Trainings, Tools development and office maintenance.			-\$24,41,029	\$ 43,10,160	\$ 26,13,897	UND P Through agency	72100/64300/74500	GAVI	\$ 9,365,086
	3.2. Technical Support Staff, Travel cost, M&E cost, Program support cost (8%)			\$ 201,696	\$201696	\$201696	UND P	72100/64300/74500	GAVI	\$605,088
	3.3. PSC (8%)			\$ 211,418	360948	225247		75100		797,613
		Sub-Total for Output 3								\$10,767,787
		Total Budget (Output 1, Output 2 and Output 3)								\$62,955,152

Under Output 1 & 2, \$ 39,646,710 is funded under activity 2.1 to 2.10 from GAVI.

Output 3 of \$ 10,767,787 is funded under activity 3.1 & 3.2 from GAVI. Total budget includes Direct Project Support Cost in activity lines.

8. GOVERNANCE AND MANAGEMENT ARRANGEMENTS

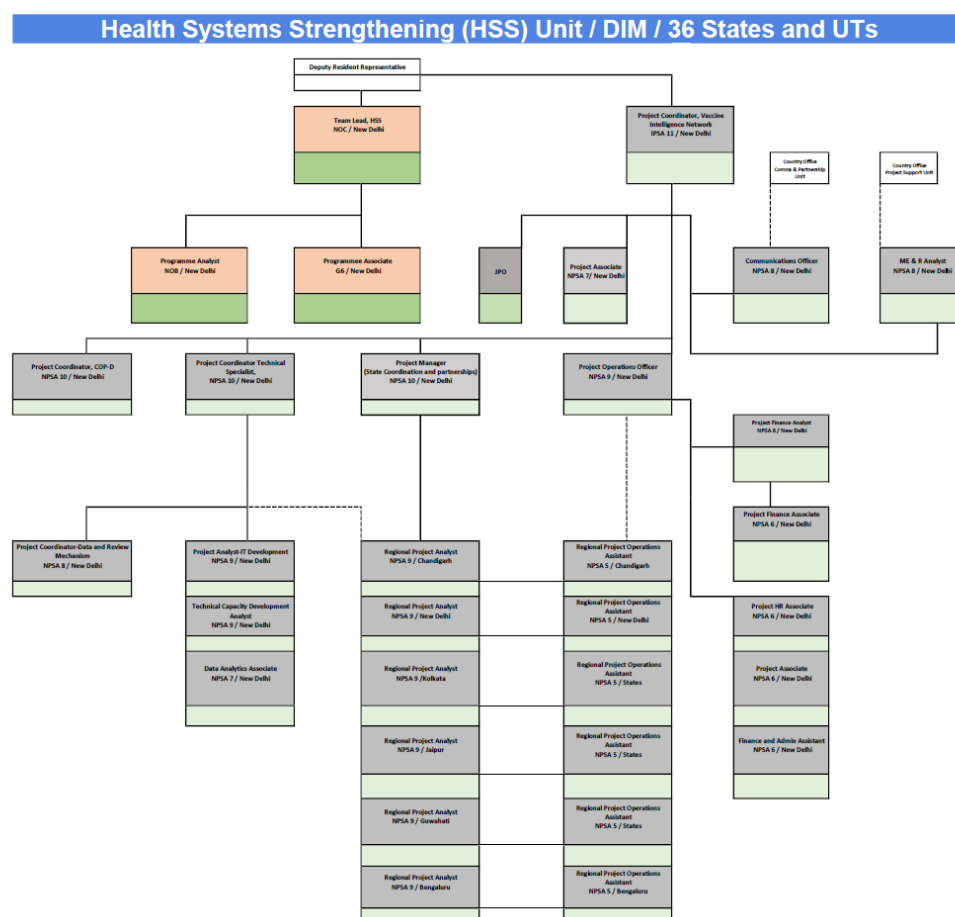
Governance Structure:

The project will be governed under two bodies:

- IAG (Immunization action group):** This forum is chaired by the Additional Secretary and Mission Director (National Health Mission) and co-chaired by Joint Secretary (RCH), MoHFW, to discuss programmatic aspects of the GAVI Health System Strengthening grant. IAG is done on a quarterly basis jointly for all partner agencies including UNDP, UNICEF and WHO and other key partners. Financial progress, output indicators and outcome indicators will be discussed during the meeting,
- Programme Steering Committee (PSC):** This Committee is chaired by UNDP's Deputy Resident Representative along with the Procurement, HR, Finance and Programme Support Units to discuss and approve the Annual work plan, delivery status, HR recruitment plan, procurement strategy and other important operations-related aspects of the project.

Project Organogram and Management Structure:

The project organogram is provided below:



Notes:

- Human resources proposed under the peach/green boxes are intended for project assurance and oversight and are not charged to Gavi HSS-3 funds
- Human resources under the grey/green boxes are supported through GAVI HSS-3 funding.

- For U-WIN implementation, the National PMU will consist of Project Managers, a Capacity Building Lead, an IT Lead, an RI Data Analytics Lead, an Operations Lead, and nodal officers for HR, Procurement, and Finance.
- The regional team will include Regional SPOs, State Leads, a Regional Operations Lead, and State IT Leads.
- Vaccine and Cold Chain Managers, under the regional structure, will be supported through State NHM funds.
- U-WIN Coordinators will be deployed based on an estimate of one coordinator for approximately 600 ANMs and 2,000 ASHAs, adjusted to meet state-specific requirements.

Project Assurance:

The UNDP Country Office will be responsible for Project Assurance that supports the Project Board by carrying out objective and independent project oversight and monitoring functions, including compliance with the risk management and social and environmental standards of UNDP. It is noted that this project assurance role is totally independent of project execution.

A designated representative of UNDP India will play the project assurance role, will present assurance findings to the Project Board, and is expected to attend all Project Board meetings and support Project Board processes as a non-voting representative, including providing Project Board members with the required documentation required to perform their duties. The UNDP representative playing the main project assurance function at national level is the Team Leader, Health System Strengthening Team in the UNDP India Country Office.

The assurance function will be carried out by the following staff at the CO level:

1. Team Leader, Health System Strengthening Team, UNDP India CO
2. Head, Programme Management Support Unit, UNDP India CO
3. Programme Associate, Health System Strengthening Team, UNDP India CO

Project Management:

The project will be implemented at the National, State and District Levels. Project Management Units will be established at each level which will primarily work in close coordination with the Immunization Division, Ministry of Health and Family Welfare, State Routine Immunisation Cell and District Immunization officers to monitor the implementation of the programme.

- **PMU at the national level:** This management structure will work under the direction of the Immunization Action Group and Technical Committee. This structure includes a Project management team along with subject matter experts for Routine Immunization and Vaccine logistics. The structure will also include resources for the operations team (Procurement, Finance, HR and Admin). This team will liaison with Central Government and donor and share project progress at IAG and Technical Committee on a regular basis.
This structure will provide necessary directions to State and District level PMUs for smooth project implementation.
- **PMU at the state level:** This structure will work as per the directions of the National PMU and liaison with state government and partner agencies for the roll-out of the project. This structure will be responsible for building the capacity at the district level team and monitoring their performance along with output and outcome indicators defined by the National PMU.
- **PMU at the Regional and district level:** This structure is at the service delivery level and works closely with the end users of the U-WIN solution including Healthcare workers, medical officers, Cold Chain handlers, Vaccinators and ASHA workers.

Their primary role includes building the capacity of healthcare workers as per the directions from PMU at state level and establishing a periodic review and monitoring mechanism. This structure will be the first point of contact for taking inputs from the field, providing resolution/ handholding support as and when required and escalating issues identified by the field to state PMU in case it cannot be addressed at their level. This structure will play a key role in the implementation and sustainability of the project.

9. LEGAL CONTEXT

Option b. Where the country has NOT signed the Standard Basic Assistance Agreement (SBAA)

The project document shall be the instrument envisaged and defined in the Supplemental Provisions to the Project Document, attached hereto and forming an integral part hereof, as “the Project Document”.

This project will be implemented by UNDP in accordance with its financial regulations, rules, practices and procedures only to the extent that they do not contravene the principles of the Financial Regulations and Rules of UNDP. Where the financial governance of an Implementing Partner does not provide the required guidance to ensure the best value for money, fairness, integrity, transparency, and effective international competition, the financial governance of UNDP shall apply.

10. RISK MANAGEMENT

Option b. UNDP (DIM)

1. UNDP as the Implementing Partner will comply with the policies, procedures and practices of the United Nations Security Management System (UNSMS.)
2. UNDP as the Implementing Partner will undertake all reasonable efforts to ensure that none of the [project funds]²⁴ [UNDP funds received pursuant to the Project Document]²⁵ are used to provide support to individuals or entities associated with terrorism, that the recipients of any amounts provided by UNDP hereunder do not appear on the United Nations Security Council Consolidated Sanctions List, and that no UNDP funds received pursuant to the Project Document are used for money laundering activities. The United Nations Security Council Consolidated Sanctions List can be accessed via <https://www.un.org/securitycouncil/content/un-sc-consolidated-list>. This provision must be included in all sub-contracts or sub-agreements entered into under this Project Document.
3. Social and environmental sustainability will be enhanced through the application of the UNDP Social and Environmental Standards (<http://www.undp.org/ses>) and related Accountability Mechanism (<http://www.undp.org/secu-srm>).
4. UNDP as the Implementing Partner will: (a) conduct project and programme-related activities in a manner consistent with the UNDP Social and Environmental Standards, (b) implement any management or mitigation plan prepared for the project or programme to comply with such standards, and (c) engage in a constructive and timely manner to address any concerns and complaints raised through the Accountability Mechanism. UNDP will seek to ensure that communities and other project stakeholders are informed of and have access to the Accountability Mechanism.
5. In the implementation of the activities under this Project Document, UNDP as the Implementing Partner will handle any sexual exploitation and abuse (“SEA”) and sexual harassment (“SH”) allegations in accordance with its regulations, rules, policies and procedures.
6. All signatories to the Project Document shall cooperate in good faith with any exercise to evaluate any programme or project-related commitments or compliance with the UNDP Social and Environmental Standards. This includes providing access to project sites, relevant personnel, information, and documentation.
7. UNDP as the Implementing Partner will ensure that the following obligations are binding on each responsible party, subcontractor, and sub-recipient:
 - a. Consistent with the Article III of the SBAA [or the Supplemental Provisions to the Project Document], the responsibility for the safety and security of each responsible party, subcontractor and sub-recipient and its personnel and property, and of UNDP’s property in such responsible party’s, subcontractor’s and sub-recipient’s custody, rests with such responsible party, subcontractor and sub-recipient. To this end, each responsible party, subcontractor and sub-recipient shall:
 - i. put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;
 - ii. assume all risks and liabilities related to such responsible party’s, subcontractor’s and sub-recipient’s security, and the full implementation of the security plan.

²⁴ To be used where UNDP is the Implementing Partner

²⁵ To be used where the UN, a UN fund/programme or a specialized agency is the Implementing Partner

- b. UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the responsible party's, subcontractor's and sub-recipient's obligations under this Project Document.
- c. Each responsible party, subcontractor and sub-recipient (each a "sub-party" and together "sub-parties") acknowledges and agrees that UNDP will not tolerate sexual harassment and sexual exploitation and abuse of anyone by the sub-parties, and other entities involved in Project implementation, either as contractors or subcontractors and their personnel, and any individuals performing services for them under the Project Document.
 - (a) In the implementation of the activities under this Project Document, each sub-party shall comply with the standards of conduct set forth in the Secretary General's Bulletin ST/SGB/2003/13 of 9 October 2003, concerning "Special measures for protection from sexual exploitation and sexual abuse" ("SEA").
 - (b) Moreover, and without limitation to the application of other regulations, rules, policies and procedures bearing upon the performance of the activities under this Project Document, in the implementation of activities, each sub-party, shall not engage in any form of sexual harassment ("SH"). SH is defined as any unwelcome conduct of a sexual nature that might reasonably be expected or be perceived to cause offense or humiliation, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment. SH may occur in the workplace or in connection with work. While typically involving a pattern of conduct, SH may take the form of a single incident. In assessing the reasonableness of expectations or perceptions, the perspective of the person who is the target of the conduct shall be considered.
- d. In the performance of the activities under this Project Document, each sub-party shall (with respect to its own activities), and shall require from its sub-parties (with respect to their activities) that they, have minimum standards and procedures in place, or a plan to develop and/or improve such standards and procedures in order to be able to take effective preventive and investigative action. These should include: policies on sexual harassment and sexual exploitation and abuse; policies on whistleblowing/protection against retaliation; and complaints, disciplinary and investigative mechanisms. In line with this, sub-parties will and will require that their respective sub-parties will take all appropriate measures to:
 - (i) Prevent its employees, agents or any other persons engaged to perform any services under this Project Document, from engaging in SH or SEA;
 - (ii) Offer employees and associated personnel training on prevention and response to SH and SEA, where sub-parties have not put in place its own training regarding the prevention of SH and SEA, sub-parties may use the training material available at UNDP;
 - (iii) Report and monitor allegations of SH and SEA of which any of the sub-parties have been informed or have otherwise become aware, and status thereof;
 - (iv) Refer victims/survivors of SH and SEA to safe and confidential victim assistance; and
 - (v) Promptly and confidentially record and investigate any allegations credible enough to warrant an investigation of SH or SEA. Each sub-party shall advise UNDP of any such allegations received and investigations being conducted by itself or any of its sub-parties with respect to their activities under the Project Document, and shall keep UNDP informed during the investigation by it or any of such sub-parties, to the extent that such notification (i) does not jeopardize the conduct of the investigation, including but not limited to the safety or security of persons, and/or (ii) is not in contravention of any laws applicable to it. Following the investigation, the relevant sub-party shall advise UNDP of any actions taken by it or any of the other entities further to the investigation.
- e. Each sub-party shall establish that it has complied with the foregoing, to the satisfaction of UNDP, when requested by UNDP or any party acting on its behalf to provide such confirmation. Failure of the relevant sub-party to comply of the foregoing, as determined by UNDP, shall be considered grounds for suspension or termination of the Project.
- f. Each responsible party, subcontractor and sub-recipient will ensure that any project activities undertaken by them will be implemented in a manner consistent with the UNDP Social and Environmental Standards and shall ensure that any incidents or issues of non-compliance shall be reported to UNDP in accordance with UNDP Social and Environmental Standards.

- g. Each responsible party, subcontractor and sub-recipient will take appropriate steps to prevent misuse of funds, fraud, corruption or other financial irregularities, by its officials, consultants, subcontractors and sub-recipients in implementing the project or programme or using the UNDP funds. It will ensure that its financial management, anti-corruption, anti-fraud and anti money laundering and countering the financing of terrorism policies are in place and enforced for all funding received from or through UNDP.
- h. The requirements of the following documents, then in force at the time of signature of the Project Document, apply to each responsible party, subcontractor and sub-recipient: (a) UNDP Policy on Fraud and other Corrupt Practices (b) UNDP Anti-Money Laundering and Countering the Financing of Terrorism Policy; and (c) UNDP Office of Audit and Investigations Investigation Guidelines. Each responsible party, subcontractor and sub-recipient agrees to the requirements of the above documents, which are an integral part of this Project Document and are available online at www.undp.org.
- i. In the event that an investigation is required, UNDP will conduct investigations relating to any aspect of UNDP programmes and projects. Each responsible party, subcontractor and sub-recipient will provide its full cooperation, including making available personnel, relevant documentation, and granting access to its (and its consultants', subcontractors' and sub-recipients') premises, for such purposes at reasonable times and on reasonable conditions as may be required for the purpose of an investigation. Should there be a limitation in meeting this obligation, UNDP shall consult with it to find a solution.
- j. Each responsible party, subcontractor and sub-recipient will promptly inform UNDP as the Implementing Partner in case of any incidence of inappropriate use of funds, or credible allegation of fraud, corruption other financial irregularities with due confidentiality.
Where it becomes aware that a UNDP project or activity, in whole or in part, is the focus of investigation for alleged fraud/corruption, each responsible party, subcontractor and sub-recipient will inform the UNDP Resident Representative/Head of Office, who will promptly inform UNDP's Office of Audit and Investigations (OAI). It will provide regular updates to the head of UNDP in the country and OAI of the status of, and actions relating to, such investigation.
- k. *Choose one of the three following options:*

Option 1: UNDP will be entitled to a refund from the responsible party, subcontractor or sub-recipient of any funds provided that have been used inappropriately, including through fraud corruption, other financial irregularities or otherwise paid other than in accordance with the terms and conditions of this Project Document. Such amount may be deducted by UNDP from any payment due to the responsible party, subcontractor or sub-recipient under this or any other agreement. Recovery of such amount by UNDP shall not diminish or curtail any responsible party's, subcontractor's or sub-recipient's obligations under this Project Document.
Where such funds have not been refunded to UNDP, the responsible party, subcontractor or sub-recipient agrees that donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities under this Project Document, may seek recourse to such responsible party, subcontractor or sub-recipient for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud, corruption or other financial irregularities, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

Note: The term "Project Document" as used in this clause shall be deemed to include any relevant subsidiary agreement further to the Project Document, including those with responsible parties, subcontractors and sub-recipients.

- l. Each contract issued by the responsible party, subcontractor or sub-recipient in connection with this Project Document shall include a provision representing that no fees, gratuities, rebates, gifts, commissions or other payments, other than those shown in the proposal, have been given, received, or promised in connection with the selection process or in contract execution, and that the recipient of funds from it shall cooperate with any and all investigations and post-payment audits.
- m. Should UNDP refer to the relevant national authorities for appropriate legal action any alleged wrongdoing relating to the project or programme, the Government will ensure that the relevant national authorities shall actively investigate the same and take appropriate legal action against all individuals found to have participated in the wrongdoing, recover and return any recovered funds to UNDP.

- n. Each responsible party, subcontractor and sub-recipient shall ensure that all of its obligations set forth under this section entitled “Risk Management” are passed on to its subcontractors and sub-recipients and that all the clauses under this section entitled “Risk Management Standard Clauses” are adequately reflected, *mutatis mutandis*, in all its sub-contracts or sub-agreements entered into further to this Project Document.

11. ANNEXES

Annex I: Project Risk Register

Project Title: Improving the efficiency of the vaccination system in India					Project Number: 01001150		Date: 01-Aug-23	
#	Event	Cause	Impact(s)	Risk Category and Sub-category (including Risk Appetite)	Impact, Likelihood & Risk Level	Risk Valid From/To	Risk Owner (individual accountable for managing the risk)	Risk Treatment and Treatment Owner
1	The interventions on ensuring the sustainability of the U-WIN may not be executed considering the timeline of the project.	The project has time-bound funding support from the donor till 2026. During the project's life cycle, the aim is to transition the U-WIN expenses to the state and national governments' funds.	It will negatively impact the continuation and sustainability of this country-wide programme.	3. OPERATIONAL (3.6. Transition and exit strategy) - UNDP Risk Appetite: EXPLORATORY TO OPEN	Likelihood: 2 - Low likelihood Impact: 3 - Intermediate Risk level: MODERATE (equates to a risk appetite of EXPLORATORY)	From: 01-Aug-23 To: 31-Dec-26	Programme Officer/Team Leader	<u>Risk Treatment 1.1:</u> UNDP liaise with the government at the national and state levels to ensure the smooth institutionalisation of project interventions. <u>Risk Treatment 1.2:</u> UNDP sign MOA/MOU/ LoA with the 36 states and the national government and foster advocacy to ensure inclusion in the government of India's annual budget through the Project Implementation Plan (PIP). <u>Risk Treatment Owner:</u> Project Manager
2	Recommendations and learnings from pilots, research and studies conducted by COP-D are not	UNDP will set up a 'Community of Practice on Demand Generation (CoP-Demand)' to steer the demand for immunization and boost the community mobilization agenda. It will	The cold response from CSOs will fail to improve the demand for immunization.	3. OPERATIONAL (3.5. Partners' engagement) - UNDP Risk Appetite:	Likelihood: 3 - Moderately likely Impact: 3 - Intermediate Risk level:	From: 01-Aug-23 To: 31-Dec-26	Programme Officer/Team Leader	<u>Risk Treatment 2.1:</u> Periodic review of CSOs to ensure that recommendations from COP-D are incorporated.

	adapted/utilized by CSOs and frontline workers.	be conducting behavioural insight (BI) studies to be adopted by CSOs. However, there is a possibility of resistance from CSOs for newer initiatives.		EXPLORATORY TO OPEN	MODERATE (equates to a risk appetite of EXPLORATORY)			<u>Risk Treatment Owner:</u> Project Manager
3	Challenges in the triangulation of data from different sources to generate action points during meetings on Routine immunization may hamper the achievement of desired objectives.	UNDP will support data triangulation of multiple data sets in place to monitor immunisation services and strengthen data review mechanisms at the last mile. It is a challenging task and may take longer than expected time or efforts.	Which will impact the achievement of one of the major results of the programme.	4. ORGANIZATIONAL (4.6. Knowledge management) - UNDP Risk Appetite: EXPLORATORY TO OPEN	Likelihood: 3 - Moderately likely Impact: 3 - Intermediate Risk level: MODERATE (equates to a risk appetite of EXPLORATORY)	From: 01-Aug-23 To: 31-Dec-26	Programme Officer/Team Leader	<u>Risk Treatment 3.1:</u> UNDP will develop data triangulation tools, to be utilized in Routine Immunization (RI) Review meetings at all levels and further strengthen the review meetings mechanism for Routine immunization. <u>Risk Treatment Owner:</u> Project Manager
4	Delay in funds disbursement by state governments may hamper the effective implementation of project activities funded through states.	The programme activities are funded through Gavi's Health System Strengthening grant (HSS-III) (2023-2026). The first tranche of funds took longer than expected. Similar situation may occur again.	Which will de-rail the programme implementation.	2. FINANCIAL (2.6. Budget availability and cash flow) - UNDP Risk Appetite: MINIMAL TO CAUTIOUS	Likelihood: 3 - Moderately likely Impact: 4 - Extensive Risk level: SUBSTANTIAL (equates to a risk appetite of OPEN)	From: 01-Aug-23 To: 31-Dec-25	Programme Officer/Team Leader	<u>Risk Treatment 4.1:</u> Regular meetings and follow-ups with the state and timely submission of statements of expenditure (SOEs) and utilization certificates (UCs) to ensure on-time disbursement of funds. <u>Risk Treatment Owner:</u> Project Manager
5	There is a risk of low adherence to U-WIN from ANM and ASHA	The project will build capacities of more than one million healthcare workers (ASHAs and ANMs) to access and use digital applications including U-	Social and economic fallout from GBV can lead to a loss of livelihood and increased gender	1. SOCIAL AND ENVIRONMENTAL (1.2. Gender equality and	Likelihood: 2 - Low likelihood Impact: 2 - Minor	From: 01-Aug-23 To: 31-Dec-26	Programme Officer/Team Leader	<u>Risk Treatment 5.1:</u> Advocacy with Government to stop paper based reporting post U-WIN pilot.

	workers due to improper work life balance and limitations to safe workplace practices.	WIN for reporting and tracking vaccination. If paper-based work and digital applications will run in parallel then it will increase the workload of ANMs and ASHA workers. Similarly if the digital solution doesn't work in low resource environment (Low network areas, older android version etc.). Then ANM and ASHA workers have to spend more time in field . ANM and ASHA workers may face domestic violence/GBV in case they spent more time in field and able to devote comparatively less time at home. Resistance community at times drive-away healthcare workers to avoid vaccination services.	inequalities in the long term.	women's empowerment) - UNDP Risk Appetite: CAUTIOUS	Risk level: LOW (equates to a risk appetite of CAUTIOUS)			<u>Risk Treatment 5.2:</u> Web solution to be developed which can work in low resource settings includes low network areas, old smartphones and multilingual interface. <u>Risk Treatment 5.3:</u> Mobile application for ANM and ASHA workers to have hyperlink to access GBV helpline and Domestic violence helpline, where they can report and get counsellor support as well. <u>Risk Treatment Owner:</u> Project Manager
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Annex II: Additional Monitoring Plan

Project Description		- Indicators
<u>Capacity building of project team</u>		
- Continue to build capacity of Senior Project Officers, Project Officers and Vaccine Cold Chain Managers - Hire and build the capacity of U-WIN coordinators		- # of refresher training organized for SPO, POs and VCCMs
		- # of U-WIN coordinators hired and trained on U-WIN
<u>Capacity building of government Health Workforce</u>		
- Continue to build the capacity of Cold Chain Handlers on vaccine logistics and cold chain management - Build capacity and hand-hold Vaccinators / Community Mobilisers on U-WIN - Build the capacity of data managers, Block Officials, District and State Immunization Officer on utilising U-WIN for routine data review		- # of Cold Chain Handlers trained on U-WIN
		- # of vaccinators/mobilisers/managers trained on U-WIN
		- # of data managers, Block officials, DIOs, and SIOs trained on utilising U-WIN for routine data review
		- # of data sets integrated with U-WIN
<u>Monitoring</u>	eVIN	- # of districts live on eVIN - # of health facilities live on eVIN - # of vaccine cold chain points routinely use eVIN - % of target cold chain equipment has a working digital temperature logger installed
	U-WIN	- # of districts and health facilities live on U-WIN - # session sites baseline vs created vs published (session published) - # Sessions planned vs held - # of Vaccinators active (created vs even 1 session held/ongoing in last 1 month) - # children (0-1 yr & 1-5 yr) and pregnant women registered - # of PW and children vaccinated (absolute number) - # Delivery points in Pvt - created vs active - # Delivery points in Govt - created vs active - # DPM - Pregnancy outcome delivery vs new-born registered vs birth dose updated
	CoP	- # of implementing partners and CSO involved - # of demand-related interventions, behavioural studies, and human-centred design pilots undertaken