GAVI Alliance

Annual Progress Report 2010

Submitted by

The Government of *Indonesia*

Reporting on year: **2010**
Requesting for support year: **2012**
Date of submission: **16.06.2011 19:42:10**

Deadline for submission: 1 Jun 2011

Please submit the APR 2010 using the online platform
https://AppsPortal.gavialliance.org/PDExtranet

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

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

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

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

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

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

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

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

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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

ARBITRATION
Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.
For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.
The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

- *Accomplishments using GAVI resources in the past year*
- *Important problems that were encountered and how the country has tried to overcome them*
- *Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*
- *Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released*
- *How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

1. Application Specification

Reporting on year: **2010**
Requesting for support year: **2012**

1.1. NVS & INS support

There is no NVS or INS support this year.

Programme extension

No NVS support eligible to extension this year.

1.2. ISS, HSS, CSO support

Type of Support	Active until
HSS	2010
CSO	2010

ISS	2010

2. Signatures

Please fill in all the fields highlighted in blue. Afterwards, please print this page, have relevant people dated and signed, then upload the scanned signature documents in Section 13 "Attachments".

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

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

For the Government of Indonesia

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

Enter the family name in capital letters.

Minister of Health (or delegated authority):		**Minister of Finance (or delegated authority)**	
Name	dr. H. Andi MUHADIR, MPH (Director of Surveillance, Immunization, Quarantine and Matra Health)	**Name**	WIDJANARKO (Act of Director of Funds, MoF)
Date		**Date**	
Signature		**Signature**	

This report has been compiled by

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.
Enter the family name in capital letters.

Full name	Position	Telephone	Email	Action
dr. Theresia Sandra Diah RATIH, MHA	EPI MANAGER	+62 21 4249024	tsandra_dratih@yahoo.co.id	

2.2. ICC Signatures Page

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

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

2.2.1. ICC report endorsement

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

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.
Enter the family name in capital letters.

Name/Title	Agency/Organisation	Signature	Date	Action
dr. Ratna ROSITA, MPHM	Secretary General of MoH			
Arsil RUSLI, SH	Act. Inspector General of MoH			
Prof. dr. Tjandra Yoga ADITAMA	Director General of Disease Control and Environtment Health			
dr. Wistianto WISNU, MPH	Secretary of DG of Nutrition and MCH			
dr. Ina HERNAWATI, MPH	Director of Maternal Health			
dr. Kirana PRITASARI, MQIH	Director of Child Health			
dr. Bambang SARDJONO. MPH	Director of Basic Health Services			
dr. Julitasari SUNDORO, MScPH, PhD	ITAGI			
dr. Yuriko EGAMI	JICA			
Imam SUBEKTI	Act. Director of Health and Nutrition of National Planning and Development Body			
DR. Bardan Jung RANA	WHO			
dr. Marisa RICARDO	UNICEF			
Rooswanti SOEHARNO	ADB			
dr. Untung Suseno SUTARJO, MKes	Chief of Bureau Planning and			

Name/Title	Agency/Organisation	Signature	Date	Action
	Budgeting of MoH			
Drs. Achmad DJOHARI	Chief of Bureau Finance			
Mohammad SHAHJAHAN	WHO			
Irene KOEK	USAID			
Claudia ROCX	WORLD BANK			
Dr. Julitasari SUNDORO, dr.,M.Sc	AEFI NATIONAL COMMITEE			
Jan ANDRIANTO	TP PKK Pusat (Women Movement Organization)			
Azizah AZIZ	PP Muslimat Nahdatul Ulama			
Helvi NURZAINI	PP Aisyah			
Tumunah WIRATNOKO	PP IBI (MIDWIVE SOCIETY ORGANIZATION			
dr. Joedyaningsih SW	KWARNAS GERAKAN PRAMUKA (SCOUT MOVEMENT)			

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

All comments will be treated confidentially

Comments from Partners:

Special Comment:
Since the members of ICC similar with HSCC, the HSCC meeting January 14th, 2011, decided that ICC will merge to HSCC to improve coordination and monitoring GAVI grant. This decision, has been legalized by Ministry of Health Decree No. 501/MENKES/SK/III/2011, dated March 2nd, 2011

Comments from the Regional Working Group:

2.3. HSCC Signatures Page

If the country is reporting on HSS

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

2.3.1. HSS report endorsement

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC) - , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.
Action.
Enter the family name in capital letters.

Name/Title	Agency/Organisation	Signature	Date	Action

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

This report has been prepared in consultation with CSO representatives participating in national level coordination mechanisms (HSCC or equivalent and ICC) and those involved in the mapping exercise (for Type A funding), and those receiving support from the GAVI Alliance to help implement the GAVI HSS proposal or cMYP (for Type B funding).

2.4.1. CSO report editors

This report on the GAVI Alliance CSO Support has been completed by

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.
Enter the family name in capital letters.

Name/Title	Agency/Organisation	Signature	Date	Action
Kodrat PRAMUDHO, SKM, MKes, PhD	Manager of Community Empowerment of Health Promotion Centre			

2.4.2. CSO report endorsement

We, the undersigned members of the National Health Sector Coordinating Committee - , endorse this report on the GAVI Alliance CSO Support.

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.
Enter the family name in capital letters.

Name/Title	Agency/Organisation	Signature	Date	Action
Arsil RUSLI	Act. Inspector General of MoH			
dr. Wistianto WISNU, MPH	Secretary of DG of Nutrition and MCH			
dr. Ina HERAWATI, MPH	Director of Maternal Health			
dr. Kirana PRITASARI, MQIH	Director of Child Health			
dr. Yuriko EGAMI	JICA			
Imam SUBEKTI	Act. Director of Health and Nutrition of National Planning and Development Body			
Azizah AZIZ	PP Muslimat Nahdatul Ulama			
Tumunah WIRATNOKO	PP IBI (MIDWIVE SOCIETY ORGANIZATION			
dr. Joedyaningsih SW	KWARNAS GERAKAN PRAMUKA (SCOUT MOVEMENT)			

Signature of endorsement does not imply any financial (or legal) commitment on the part of the partner agency or individual.

3. Table of Contents

This APR reports on Indonesia's activities between January - December 2010 and specifies the requests for the period of January - December 2012

Sections

4. Baseline and Annual Targets

Table 1: baseline figures

Number	Achievements as per JRF	Targets				
	2010	2011				
Total births	4,807,853	4,538,102				
Total infants' deaths		122,030				
Total surviving infants	4,807,853	4,416,072				
Total pregnant women	5,288,638	4,991,912				
# of infants vaccinated (to be vaccinated) with BCG	4,657,901	4,311,197				
BCG coverage (%) *	97%	95%				
# of infants vaccinated (to be vaccinated) with OPV3	4,500,404	3,974,465				
OPV3 coverage (%) **	94%	90%				
# of infants vaccinated (or to be vaccinated) with DTP1 ***	4,696,741	4,195,269				
# of infants vaccinated (to be vaccinated) with DTP3 ***	4,540,904	4,195,269				
DTP3 coverage (%) **	94%	95%				
Wastage[1] rate in base-year and planned thereafter (%)	40%	40%				
Wastage[1] factor in base-year and planned thereafter	1.67	1.67				
Infants vaccinated (to be vaccinated) with 1st dose of Measles	4,472,291	3,974,465				
Measles coverage (%) **	93%	90%				
Pregnant women vaccinated with TT+	3,673,668	3,993,530				
TT+ coverage (%) ****	69%	80%				
Vit A supplement to mothers within 6 weeks from delivery						

Number	Achievements as per JRF	Targets				
	2010	2011				
Vit A supplement to infants after 6 months	2,863,126					
Annual DTP Drop-out rate [(DTP1 - DTP3) / DTP1] x 100	3%	0%				

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of total surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women
[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2010 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2010**. The numbers for 2011 to 2015 in the table on section 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in the previous APR or in the new application for GAVI support or in cMYP.

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

Provide justification for any changes in **births**

The numbers of birth in 2010 was based on the actual numbers of birth reported by Districts to Provinces and provinces to central along with regular coverage report using the National RR Immunization Form. So each province has their own data for targeted birth for each year and sent it as their administrative data to central level.

In 2010, total number of targeted birth from all administrative report is 4,807,853 larger than targeted birth in the APR 2009 (4,484,998 births).

The number of targeted birth for 2011-2015 was calculated based on SUPAS (Survey Inter Census 2005 with CBR of 19.2 and IMR 23.9 to 26.9). This number is consistent with data in new cMYP 2010-2014.

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

In 2010, Indonesia still use birth as the denominator for all of basic immunization (infant immunization), because Central Statistic Body (Badan Pusat Statistik – BPS) just have IMR at province level and this numbers is not well known by district officers. In 2011 Indonesia will start to use surviving infant denominator.

Provide justification for any changes in **targets by vaccine**

Target by vaccine written on APR 2009 based on the immunization target cMYP 2007 – 2011 are BCG 100%, Measles and OPV3 100% and DPT3 100%, however along with the new government era, the new National Strategic Planning 2010 – 2014 (RENCANA STRATEGIC 2010-2014) has been developed, so the cMYP has been revised for the years 2010-2014. In the new cMYP, there are some changes on the target by vaccine (BCG 95%, Measles and OPV3 90%, for DPT3 95%).

Provide justification for any changes in **wastage by vaccine**

Wastage by vaccine is in line with the new cMYP 2010-2014. The wastage of vaccine target could not reduce doe to the geographical condition in Indonesia, we have more than 3.000 small habitant islands and some area have low population density. So the wastage of vaccine will be higher compare with the high population density area.

5.2. Immunisation achievements in 2010

5.2.1.

Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2010 and how these were addressed

Based on the administrative reports in 2010, Indonesia has not achieved the target as stated in the APR of 2009, but based on the target declared in new cMYP only DPT3 coverage (94.5%) and HB birth dose (75.3%) has not met the target (DPT3: 95% and HB birth dose: 80%). Despite, the high coverage on the national level, there are still pockets of low coverage in some areas and endemic cases of diphtheria and measles with outbreaks.

Since decentralization, the role of EPI Unit, MOH at central level was limited to provide policy, standardization program, technical supports, and vaccine - syringe supplies only, while the operational costs were provided by the local government. The responsibility on providing basic government services is shifted to the district officials. Although, the regulation has been stated that EPI operational cost should be provided by province and district government, not all local governments allocated adequate fundings for the operational costs to the EPI programs such as training, supportive supervisions and maintenance of coldchain. Moreover, there were also competitions among other sectors since health was not put as a priority in their budget allocations.

To solve this problem, Indonesia has been conducted a comprehensive program which is called GAIN UCI (the Movement of Immunization Acceleration to reach Universal Child Immunization). In GAIN UCI we advocate various strategies such as for the area with high access and high drop out will be focused on the promotion of the importance to complete immunization especially in large and highly populated villages. The strategy for the remote area with low coverage is integrated with other programes on specific schedulles in the local area to optimize limited resources. We will sustain quality of immunization for the area with high coverage and low drop out to increase public trust.

The remaining GAVI budget (US$ 1,663,593) from Grant Phase I has been used for :
1. At the Central Level :
a. Coordination meeting for GAIN UCI (Immunization Acceleration Movement) socialization to Provincial Health Officer, national and provincial stakeholders.
b. Technical assistant to the province and district health officer for planning and implementation of GAIN UCI.
c. Conducting EVSM at 10 province to assess capacity of vaccine storage and distribution capability at provincial and district level due to NVS forthcoming introduction.
d. Conducting DQS at 8 province to assess and improving quality of data at province, district until delivery site.
e. Developed online Reporting and Recording system based on individual data by villages on Yogyakarta Province. This system is expected to be able to minimize the double counting or over reporting.
f. Developed draft of immunization waste management that will be used as a guideline at provincial and district level.
g. Developed tools and manual Indonesia cMYP to help mid level managers of provincial and district to make an integrated and comprehensive plan for their own area. This tools and manual has been trial at all districts of Central Java and West Nusa Tenggara Province.
h. Mid-term review for all EPI manager of Provinces at Bandung. At this meeting we found that every provinces has been planned to conduct GAIN UCI and prepare to achieve all the National Target especially UCI villages target.
i. Incentive of 10 Province EPI supervisors to conduct supportive supervision for all district especially district with low performance.
j. Conducted technical assistance for Provinces and Districts in accordance with their request.
k. Conducting coordinating meeting at central level for ICC, ITAGI, TWG and National AEFI Committee.
l. Conducting assessment for preparation of Cold Room Installation at three provinces.
m. Conducting inventory vaccine stock at central vaccine storage every three months to assess vaccine management including logistic report.
n. Conducting review and revise Ministry decree of Immunization Guideline based on new law of health (Law of Health Number 36/2009).

2. At the Province and District Level
a. Conducting Cold Chain maintenance at 16 provinces.
b. Conducting training of DQS, Cold Chain Management and Basic Health Workers at 6 Provinces.
c. Developed and printing IEC material for Immunization program at South Kalimantan province.
d. Conducting sweeping at 26 Provinces to catch the un-immunized babies.
e. Conducting supportive supervision from province to district and district to public health center at 31 Provinces.
f. Conducting DQS from province to district and district to public health center at 14 Provinces.
g. Conducting coordination meeting at provincial level (28 Provinces).
h. Conducting vaccine distribution from province to district at West Sumatera, Bengkulu, Central Sulawesi and Bali.

At central level, it was found that the chronic annual vaccine procurements were delayed due to the administrative issues. In 2011, we already planned to increase of buffer stock at central level, to avoid short of vaccine.

5.2.2.

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

National coverage for all antigens already reached the target, except DPT3 and HB birth dose.

The DPT3 problems are:
1. High drop out in some area
2. Lack of information
3. Some parents are afraid with side effect after their experience from DPT-HB vaccination before

4. Children with minor ill has not been immunized because of parents rejection and also some of vaccinators lack of confident to give immunization

The challenge to reach the HB Birth dose target are:
1. Some area especially at remote area still found birth delivery assisted by traditional birth attendance.
2. Still found miss opportunity (delivered at health facilities or attended by trained health staff but do not give HB birth dose vaccination),
this can be seen that national coverage for birth delivery by trained birth attendances (obsgyns, doctors, midwives and nurses) is more than 80%, but HB birth dose coverage is only 75.6%.
3. Midwives and nurses refused to give injection to newborn baby or parents rejected to get injection.
4. Deficiency of Vitamin K cases in newborn baby was often found, also the co-incidence AEFI with bleeding post HB injection often found, that made parents and midwives/nurses reluctant to give HB birth dose injection.
5. Under reported (HB birth dose given by village midwives as a part of delivery service package, but do not report to immunization staff).

5.2.3.

Do males and females have equal access to the immunisation services? Yes

If No, please describe how you plan to improve the equal access of males and females to the immunisation services.

If no data available, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? Yes

If Yes, please give a brief description on how you have achieved the equal access.

Yes, from the planning, organizing, actuating until controlling we are respecting to all gender, but for the CBAW and PW TT women are provided with basic access because they are more vulnerable when they get pregnant and give birth. Generally local culture, policy and practices do not discriminate access to basic services for young boys and girls and also to women.

Some survey can show that all genders have been relatively get same result:
Tabel 1. Routine immunization status by gender (crude card and history),Immunization Coverage Survey, 2007

Routine Immunization Status	Male		Female	
	Number	Percent	Number	Percent
Not immunized	358	3.8	351	4.0
Partially	3,017	32.0	2,624	29.9
Fully immunized	6,054	64.2	5,800	66.1
	9,430	100.0	8,774	100.0

Accordingly, result of MoH Basic Health Survey that done in 2007 and 2010 indicate that there is no significant difference in the immunization status between male and female children as shown in Table 2 and 3 below.

Table 2. Percentage of children aged 12-23 months who received basic immunization by respondent characteristic, Basic Health Survey 2007

Sex	BCG	OPV3	DPT3	HB3	Measles
Male	87.3	71.0	67.7	63.2	82.0
Female	86.5	70.1	67.6	62.3	81.2

Tabel 3. Percentage of children aged 12-23 months who received basic immunization by respondent characteristic, Basic Health Survey 2010

Sex	BCG	OPV	DPT-HB	Measles
Male	77.5	66.5	62.1	74.2
Female	78.2	67.0	61.7	74.6

5.2.4.

Please comment on the achievements and challenges in 2010 on ensuring males and females having equal access to the immunisation services

Immunization service in Indonesia from the beggining never discriminate the service to target based on gender. This evidenced and represent with the result of health surveys and coverage survey in 2007, also from Basic Health Survey 2010 which conducted in Indonesia, that has been showed no significant difference in the immunization status between male and female children as shown in graphs that will can be seen at the attachment

As mention above, that all gender have same access to the immunization services, but we did not yet develop a new reporting format to separate male and female children. We plan to adjust reporting form based on gender start from 2011.

5.3. Data assessments

5.3.1.

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

There is Basic Health Survey have been done in 2010, and national surveys had been carried out (Coverage survey, Basic Health Survey and DHS) between 2007 and 2008. The result of surveys showed that no significant difference by reported coverage and other two surveys except there was descrapancy in DTP3 coverage.. The survey result was sent to WHO-HQ, and mentioned in the JRF for WHO/UNICEF. This data was incorporated by WHO in their global estimation table. The result showed in the table below.

National Administrative Report VS Data Survey in 2009-2010

ANTIGEN	Routine Report		Routine Report Estimate	Country Best Estimate		WHO-UNICEF Estimate		Country Best	Coverage Survey	Basic Health Survey
	2009	2010		2009	2010			2007		
BCG	95	96.9	93	NA	96.9	91	77.9			
DPT1	97	97.8	89	NA	94	87	NA			
DPT3	94	94.5	82	82	83.4	75	61.9			
POLIO3	94.6	93.2	89	NA	93.2	83	66.7			
MEASLES		92	93.1	82	NA	88.6	80	74.4		
TT2+	74	70.6	73	NA	70.6	72	NA			

Country best estimate 2009 and 2010 based on correction factor that calculated from the difference between administrative report 2006 and national coverage survey 2007. We choose the national coverage survey because this survey conducted special for immunization and sample size is representative.

Data above shows the differences between country best estimate, administrative data and survey especially for DTP3 coverage. But, data from country best estimate already in line with WHO/UNICEF best estimate. It means central government has realized that data from administrative report still need to be validated by conducting meetings with National Planning Office, conduct regular and supportive DQS especially at posyandu and puskesmas level, issue national/local policies and tools to strengthen, optimalize RR system and need to conduct coverage survey at 2011/2012.

***** Please note that the WHO UNICEF estimates for 2010 will only be available in July 2011 and can have retrospective changes on the time series.

5.3.2.

Have any assessments of administrative data systems been conducted from 2009 to the present? Yes

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

We conducted DQS (Data Quality Self-Assessment) to monitor management (accuracy, completeness, timeliness) and quality of administrative data at provincial level down to the delivery side. These activities were done at the first quarter each year.

In 2010, Data Quality Self Assessment had been conducted at 10 provinces: South Sulawesi, South East Sulawesi, Central Sulawesi, South Kalimantan, East Kalimantan, North Sulawesi, West Sulawesi, Central Kalimantan, West Kalimantan and DKI Jakarta covering 23 districts, 52 Health Centres and 120 villages. The result is shown at the graphs below.

The assessment was on the accuracy of DTP-HB3 and measles absolute coverage at province, district and health center level. These graphs have shown that there are still found inaccurate data at all levels especially at the lowest source level- village and health center with an accuracy rate of only 13%.

From our observation, we found that:
a. In the village level, the inaccurate data occurred because lack of competency and consistency the volunteers cadre and vaccinators to fill the report form. There is no single identity numbers for the babies, that can be source of double counting especially those with different nick names.
b. In the district level and province level, the inaccurate took place because the incomplete and in consistence reports came from health center

5.3.3.

Please describe any activities undertaken to improve administrative data systems from 2008 to the present.

To solve this problems, during the DQS we also conducted on the job training for the volunteer cadres and vaccinators in the villages and give technical assistance for data management and feedback to province, district and health center as inputs to improve the quality of their administrative data. To ensure there have been any changes, DQS activities should follow with close monitoring, however, this cannot be done due to lack of budget.

5.3.4.

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

To make further improvements to administrative data systems, we have developed some activities such as:

- Conducted DQS as monitoring tools on regular basis at central, province and district levels.
- Developing a tool that is web-based immunization report. This tool has been developed based on individual data to reduce double counting and completeness of immunization received for each babies. This tool has been tried in 5 districts in Yogyakarta province.
- Revised RR format for each administration level and used this form for all administration levels.
- Develop integrated cohort form with MCH and Nutrition program.
- Updated MCH book for the maternal and infants integrate with MCH,Nutrition and health promotion program.. These books contains of history of pregnancy, immunization, child growth, nutritional, health condition. Also, it contained with EIC material for the parents.

To accelerated the improvement of administrative data system, we will work to gather with HSS component in the 2012. In the mean time, using Government budget we will use all the opportunity meeting with provinces and districts health officers to encourage them the importance of improving their data.

5.4. Overall Expenditures and Financing for Immunisation

The purpose of **Table 2a** and **Table 2b** below is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill-in the table using US$.

Exchange rate used	1 $US = 11439.96	Enter the rate only; no local currency name

Table 2a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.

Expenditures by Category	**Expenditures Year 2010**	**Sources of Funding**							**Actions**
		Country	**GAVI**	**UNICEF**	**WHO**	**Donor name**	**Donor name**	**Donor name**	
Traditional Vaccines*	39,620,185	39,620,185							
New Vaccines									
Injection supplies with AD syringes	7,473,044	7,473,044							
Injection supply with syringes other than ADs									
Cold Chain equipment	487,000								
Personnel	73,721	73,721							
Other operational costs	1,729,793	869,553	747,710	56,583	55,947				
Supplemental Immunisation Activities	8,227,865	6,498,206	90,043	2,153,494	515,235				
Total Expenditures for Immunisation	*57,611,608*								
Total Government Health		54,534,709	837,753	2,210,077	571,182				

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

Table 2b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.
Note: To add new lines click on the ***New item*** icon in the ***Action*** column

Expenditures by Category	Budgeted Year 2012	Budgeted Year 2013	Actions
Traditional Vaccines*	52,970,301	57,717,331	
New Vaccines		10,496,878	
Injection supplies with AD syringes	10,597,901	11,657,691	
Injection supply with syringes other than ADs			
Cold Chain equipment	5,337,888	10,675,777	
Personnel	81,093	89,202	
Other operational costs	577,053	634,759	
Supplemental Immunisation Activities			
Total Expenditures for Immunisation	69,564,236	91,271,638	

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

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

Based on the immunization financing analysis from cMYP document:
1. The budget will be increased for the next 3 years around 20% annually due to the inflation and additional targets
2. The proportion of immunization financing for the last 3 years were:
a. The secured funding which was 65-70% of the total needed. These funds sourced from:
• Central 15%
• Province 5%
• District / City 40%
• Donors 40%
b. The probable funding which was 30-35% of the total needed and obtained from various ways and efforts although it has not fully met the
needs. These funds sourced from:
• Central 40%
• Province 7-8%
• District / City 20-25%
• Donor 30-35%

This analysis has shown that the donors funds are still required to keep the sustainability of immunization program. Therefore, for the next 3 years, we still need support from the donors including GAVI.

5.5. Inter-Agency Coordinating Committee (ICC)

How many times did the ICC meet in 2010? 3

Please attach the minutes (Document number 4) from all the ICC meetings held in 2010, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.4 Overall Expenditures and Financing for Immunisation

ICC and HSCC met in 2010 for 3 times :
1. 19th April to endors the ISS component in APR 2010
2. 7th May to endors the HSS and CSO component in APR 2010
3. 18th August to endors the revised APR 2010

Are there any Civil Society Organisations (CSO) member of the ICC ?: Yes

If Yes, which ones?
Note: To add new lines click on the ***New item*** icon in the ***Action*** column.

List CSO member organisations:	Actions
Pediatrician society	
Midwives society	
Perdhaki (Women Catholic Society)	
Aisyah (Women Moslem society)	
Muslimat NU (Women Moslem Society)	
PKK (Women Welfare Movement)	

5.6. Priority actions in 2011 to 2012

What are the country's main objectives and priority actions for its EPI programme for 2011 to 2012? Are they linked with cMYP?

The objectives of EPI programme for 2011 to 2012 are:
a. To achieve the UCI (Universal Child Immunization) villages
b. To achieve the termination of poliomyelitis transmission chain and certification of polio free.
c. To achieve the elimination of Maternal and Neonatal Tetanus (incidence below 1 per 1000 live births in one year).
d. To achieve Measles Mortality.
e. To implement the introduction of new vaccines, especially Hib, JE and Pneumococc gradually as part of efforts to reduce morbidity, mortality
and disability by VPD.
f. To achieve the quality immunization services according to WHO standards.

The priority actions of EPI programme for 2011 to 2012 are:
1. Availability of Norms, Standards, Procedures, and Criteria (NSPC) for routine and supplementary immunization activities (SIAs)
2. The achievement of routine and additional immunization coverage that was equitable and quality.
3. Implementation of an effective immunization reporting, efficient, timely and complete.
4. Monitoring and evaluation of immunization activities to strengthen the immunization activities.
5. Improving data validity in all administrative levels.
6. Improving the procurement and logistics management of immunization.
7. Improving the quality of vaccines and safe injection.
8. Improving surveillance AEFI and VPD.
9. Planning the vaccines needs for global epidemic preparedness.
10. Improving the IEC to enhance commitment and support from stakeholders (government and community/ society).
11. Increasing the human resources capacity on service provision, managing routine and SIAs
12. Ensuring the sustainability and effectiveness of the use of new vaccine technology.

Both of objectives and priority actions are linked with new cMYP 2010-2014.

The fact of the most cause of death of children under 5 yrs old in Indonesia is the diarrhea or 28% of all cause of death (Basic Health Survey, 2007)and from the surveillance study in 6 Hospitals in 6 Provinces, has showen that Rotavirus has been responsible 40-60% diarrhea inpatient which is more than 40% on the severe conditions and cab be lead to death. With the more chance of the Biofarma (Government vaccine manufacture)can produce the vaccine in the nearer future, MoH will more consider the introduction of Rotavirus and Japanese Encephalitis vaccine especially for the endemic area for rather than pneumoccoc vaccine into the EPI Program.

5.7. Progress of transition plan for injection safety

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

Please report what types of syringes are used and the funding sources of Injection Safety material in 2010

Note: To add new lines click on the ***New item*** icon in the ***Action*** column.

Vaccine	Types of syringe used in 2010 routine EPI	Funding sources of 2010	Actions
BCG	Auto Disable Syringe (ADS) 0.05 ml	GOI	
Measles	Auto Disable Syringe (ADS) 0.5 ml	GOI	
TT	Auto Disable Syringe (ADS) 0.5 ml	GOI	
DTP-containing vaccine	Auto Disable Syringe (ADS) 0.5 ml	GOI	
IPV	Auto Disable Syringe (ADS) 0.5 ml	WHO	

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

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan? (Please report in box below)

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

The injection safety policy has been included in Guideline Immunization Program. In some area, local government have still faced obstacles in providing of trained health workers and issue of high turn over health workers. This problem needs to follow up with supervision and training to conduct safe injection practices.

Please explain in 2010 how sharps waste is being disposed of, problems encountered, etc.

There is none for National sharp waste management policy. MOH has developed the draft of National Sharp Waste Management in 2010. We still wait for the Ministry decree to legalize that policy. But at the district level, they have their own policy for sharpe waste management based on their facilities such as: incinerator, needle cutter, Pin hole, open burning followed by closed dumping, or burial etc.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2010

	Amount
Funds received during 2010	US$ 0
Remaining funds (carry over) from 2009	US$ 1,663,593
Balance carried over to 2011	US$ 287,584

Please report on major activities conducted to strengthen immunisation using ISS funds in 2010

The remaining GAVI budget (US$ 1,663,593) from Grant Phase I has been used for EPI Program at national and sub-national level:
1. At the national Level the activities are:

a. Conducting coordination meeting for GAIN UCI (Immunization Acceleration Movement) socialization to Provincial Health Officer, national and provincial stakeholders. GAIN UCI is a comprehensive program to accelerate achievement of UCI for all villages in Indonesia by 2014. In GAIN UCI we advocate various strategies such as for the area with high access and high drop out will be focused on the promotion of the importance to complete immunization especially in large and highly populated villages. The strategy for the remote area with low coverage is integrated with other programes on specific schedulles in the local area to optimize limited resources. We will sustain quality of immunization for the area with high coverage and low drop out to increase public trust. This coordination meeting has been proposed to socialize the strategies and to get support from the stakeholders.

b. Technical assistant to the province and district health officer for planning and implementation of GAIN UCI. This activities is a further activities to educate and help provincial and district health officers to make comprehensive planning-budgeting and to gain support from the decision makers at their level.

c. Conducting EVSM at 10 province to assess capacity of vaccine storage and distribution capability at provincial and district level due to NVS forthcoming introduction. We realized that to implement NVS we should prepare the higher quality of immunization management including vaccine and cold chain. Since we had not been capable to do the EVM, we hope that conducting the EVSM in the weaker Provincial Health Offices (PHO), we could improve vaccine and cold chain management.

d. Conducting DQS at 8 province to assess and improving quality of data at province, district until immunization post. DQS activities proposed to assess the quality of data since immunization post till PHO, beside we also used this activities to conduct on the job training to PHO, District Health Office (DHO) and Puskesmas staffs how to ensure the quality of data.

e. Developed computerize reporting and recording system based on individual data by villages on Yogyakarta Province. This system is expected to be able to minimize the double counting/over reporting or under reporting. Since ISS reward for Indonesia has been canceled and HSS aim to improve health system including data quality, we will collaborate to spread this activities to others province.

f. Developed draft of immunization waste management that will be used as a guideline at provincial and district level. The immunization waste management has been managed by local policies that some area had poor management. This guideline will provide the alternative way could be chosen based on their capability and situation at the their own site.

g. Developed tools and manual Indonesia cMYP to help mid level managers of provincial and district to make an integrated and comprehensive plan for their own area. This tools and manual has been trial at all districts of Central Java and West Nusa Tenggara Province. In the future, we will ask HSS to spread this cMYP by conducting on the job training or assistance for PHO and DHO immunization planning staffs.

h. Mid-term review for all EPI manager of Provinces at Bandung. At this meeting we found that every provinces has been planned to conduct GAIN UCI and prepare to achieve all the National Target especially UCI villages target. This meeting proposed to review the PHO and DHO activities recording to their plan to achieved their target on immunization.

i. Incentive of 10 Province EPI supervisors to conduct supportive supervision for all district especially district with low performance. This activity is the carried on activities from 2009. Since ISS reward had been canceled and the availability of the remaining ISS budget, the EPI supervisor could only be hired up to June 2010.

j. Conducted technical assistance for Provinces and Districts in accordance with their request.

k. Conducting coordinating meeting at central level for ICC, ITAGI, TWG and National AEFI Committee. The ICC meeting is conducted twice in 2010, the main issue had been raised in that meeting is the endorsement of APR 2008 and 2009, also the differences of official reported and WHO/Unicef estimated data, and the alternative way to strengthening the quality of immunization data. The ITAGI met 4 times in this year. They has been produced recommendation on H1N1 vaccine, New vaccine introduction including HIB vaccine, Diphtheria vaccination scheme against outbreaks at East Java Province and increasing Hepatitis B component dose in DPT/HB vaccine.

l. Conducting assessment for preparation of Cold Room Installation at three provinces. In 2009, cold room equipments had been donated by Unicef, the donation did not included with the fright and installment cost. To cover this cost, ISS fund had been used, including pre-installment assessment, installment and review visit to the site.

m. Conducting inventory vaccine stock at central vaccine storage every three months to assess vaccine management including logistic report. The main storage of vaccine has been decided at the Biofarma Vaccine Manufacture site in Bandung, West Java Province. To supervised and monitoring vaccine stock and management we conduct this activities.

n. Conducting review and revise Ministry decree of Immunization Guideline based on new law of health (Law of Health Number 36/2009). In 2009, the new Law of Health Number 36/2009, had been launch, and had been asked to develop new immunization guideline. The ISS fund has been used for this purpose.

2. At the Province and District Level, the ISS fund has been used to fill up the operational budget gap of immunization at the province and district level such as:
a. Conducting Cold Chain maintenance at 16 provinces.
b. Conducting training of DQS, Cold Chain Management and Basic Health Workers at 6 Provinces.
c. Developed and printing IEC material for Immunization program at South Kalimantan province.
d. Conducting sweeping at 26 Provinces to catch the un-immunized babies.
e. Conducting supportive supervision from province to district and district to public health center at 31 Provinces.
f. Conducting DQS from province to district and district to public health center at 14 Provinces.
g. Conducting coordination meeting at provincial level (28 Provinces).
h. Conducting vaccine distribution from province to district at West Sumatera, Bengkulu, Central Sulawesi and Bali.

6.2. Management of ISS Funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2010 calendar year? Yes

If Yes, please complete Part A below.
If No, please complete Part B below.

Part A: briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of ISS funds

The Aide Memoire has been shared between GAVI and MoH, until now, the original has not yet received. In the mean time, the MoH has taken into consideration to met Gavi conditions in the management of ISS funds such as:
1. Gavi funds has been putting in the State Budget document that has been sign by MoF and MoH since 2010.
2. By putting in the State Budget document, Gavi funds will be subjected in the internal and external audit scheme, but since Gavi ask the MoF signature
for the APR, Gavi Funds will be mandatory audited by external audit (BPKP), annually.
3. The Gavi funds has been putting in the bank account that has been known and approved by MoF.
4. To strengthening the coordination and synchronizing activities to increase immunization coverage between HSS, CSO and ISS, MoH has changed the
secretariat personnel and to review Project Implementation Manual (PIM) that include the financial implementation manual (FIM).
5. etc.

Hopefully, the original Aide Memoire will be sent soon, so the remaining CSO's fund could be sent, and the activities of CSOs can be restart.

Part B: briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process

Is GAVI's ISS support reported on the national health sector budget? Yes

6.3. Detailed expenditure of ISS funds during the 2010 calendar year

Please attach a detailed financial statement for the use of ISS funds during the 2010 calendar year (Document Number 8) (Terms of reference for this financial statement are attached in Annex 1). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your ISS programme during your government's most recent fiscal year, this must also be attached (Document Number 18).

6.4. Request for ISS reward

In June 2009, the GAVI Board decided to improve the system to monitor performance of immunisation programmes and the related calculation of performance based rewards. Starting from 2008 reporting year, a country is entitled to a reward:

a) If the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the original target set in the approved ISS proposal), and

b) If the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year, which will be published at http://apps.who.int/Immunisation_monitoring/en/globalsummary/timeseries/tscoveragedtp3.htm.

If you qualify for ISS reward based on DTP3 achievements in 2010 immunisation programme, estimate the US$ amount by filling **Table 3** below

Note: The Monitoring IRC will review the ISS section of the APR after the WHO/UNICEF coverage estimate is made available

Table 3: Calculation of expected ISS reward

				2009	2010
				A	B
1	Number of infants vaccinated with DTP3* (from JRF) **specify**			4,846,313	4,540,904
2	Number of **additional** infants that are reported to be vaccinated with DTP3				-305,409
3	Calculating	$20	per additional child vaccinated		-6,108,180

				2009	2010
				A	B
			with DTP3		
4	**Rounded-up estimate of expected reward**				**-6,108,000**

* Number of DTP3: total number of infants vaccinated with DTP3 alone plus the number of those vaccinated with combined DTP-HepB3, DTP-HepB-Hib3.

** Base-year is the previous year with the highest DTP3 achievement or the original target set in the approved ISS proposal, whichever is higher. Please specify the year and the number of infants vaccinated with DTP3 and reported in JRF.

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

There is no NVS support this year.

8. Injection Safety Support (INS)

There is no INS support this year.

9. Health System Strengthening Programme (HSS)

The HSS form is available at this address: HSS section of the APR 2010 @ 18 Feb 2011.docx

Please download it, fill it in offline and upload it back at the end of this current APR form using the Attachment section.

10. Civil Society Programme (CSO)

The CSO form is available at this address: CSO section of the APR 2010 @ 18 Feb 2011.docx

Please download it, fill it in offline and upload it back at the end of this current APR form using the Attachment section.

11. Comments

Comments from ICC/HSCC Chairs

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

12. Annexes

Annex 1

TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR IMMUNISATION SERVICES SUPPORT (ISS) AND NEW VACCINE INTRODUCTION GRANTS

I. All countries that have received ISS /new vaccine introduction grants during the 2010 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2010, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2010 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.
   a. Funds carried forward from the 2009 calendar year (opening balance as of 1 January 2010)
   b. Income received from GAVI during 2010
   c. Other income received during 2010 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2010
   f. A detailed analysis of expenditures during 2010, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2010 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2010 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2008 (balance as of *31Decembre 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57 493 200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2009	30,592,132	63,852
Balance as of 31 December 2009 (balance carried forward to 2010)	60,139,325	125,523

* An average rate of CFA 479,11 = UD 1 applied.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12 650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4 000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1 000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

Annex 2

TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR HEALTH SYSTEMS STRENGTHENING (HSS)

I. All countries that have received HSS grants during the 2010 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2010, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2010 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on next page.
   a. Funds carried forward from the 2009 calendar year (opening balance as of 1 January 2010)
   b. Income received from GAVI during 2010
   c. Other income received during 2010 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2010
   f. A detailed analysis of expenditures during 2010, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2010 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2010 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2008 (balance as of *31Decembre 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57 493 200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2009	30,592,132	63,852
Balance as of 31 December 2009 (balance carried forward to 2010)	60,139,325	125,523

* An average rate of CFA 479,11 = UD 1 applied.

Detailed analysis of expenditure by economic classification ** – GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12 650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4 000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1 000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

Annex 3

TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR CIVIL SOCIETY ORGANISATION (CSO) TYPE B

I. All countries that have received CSO 'Type B' grants during the 2010 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2010, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2010 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.
   a. Funds carried forward from the 2009 calendar year (opening balance as of 1 January 2010)
   b. Income received from GAVI during 2010
   c. Other income received during 2010 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2010
   f. A detailed analysis of expenditures during 2010, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2010 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2010 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR CSO 'Type B' FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2008 (balance as of *31Decembre 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57 493 200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2009	30,592,132	63,852
Balance as of 31 December 2009 (balance carried forward to 2010)	60,139,325	125,523

* An average rate of CFA 479,11 = UD 1 applied.

Detailed analysis of expenditure by economic classification ** – GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12 650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4 000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1 000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

13.1. List of Supporting Documents Attached to this APR

Document	Section	Document Number	Mandatory *
Signature of Minister of Health (or delegated authority)		1	Yes
Signature of Minister of Finance (or delegated authority)		2	Yes
Signatures of members of ICC		3	
Signatures of members of HSCC		5, 17	Yes
Minutes of ICC meetings in 2010		4	
Minutes of ICC meeting in 2011 endorsing APR 2010			
Minutes of HSCC meetings in 2010		6	Yes
Minutes of HSCC meeting in 2011 endorsing APR 2010		7	Yes
Financial Statement for ISS grant in 2010		8	
Financial Statement for CSO Type B grant in 2010		9	Yes
Financial Statement for HSS grant in 2010		19	Yes
EVSM/VMA/EVM report		11	
External Audit Report (Fiscal Year 2010) for ISS grant		18	
CSO Mapping Report (Type A)			
New Banking Details		16	
new cMYP starting 2012		14	
Summary on fund utilisation of CSO Type A in 2010		10	
Financial Statement for NVS introduction grant in 2010			
External Audit Report (Fiscal Year 2010) for CSO Type B grant			
External Audit Report (Fiscal Year 2010) for HSS grant			
Latest Health Sector Review Report			

13.2. Attachments

List of all the mandatory and optional documents attached to this form

Note: Use the ***Upload file*** arrow icon to upload the document. Use the ***Delete item*** icon to delete a line. To add new lines click on the ***New item*** icon in the ***Action*** column.

ID	File type Description	File name Date and Time Size	New file	Actions
1	**File Type:** Signature of Minister of Health (or delegated authority) * **File Desc:** Signature of MoH delegated authority	**File name:** APR_Signature of MOH.pdf **Date/Time:** 31.05.2011 03:23:42 **Size:** 1 MB		
2	**File Type:** Signature of Minister of Finance (or delegated authority) * **File Desc:** Signature of MoF delegated authority	**File name:** MoF Signature.pdf **Date/Time:** 16.06.2011 07:38:27 **Size:** 401 KB		
3	**File Type:**	**File name:**		

ID	File type Description	File name Date and Time Size	New file	Actions
	Signatures of members of ICC * **File Desc:** The HSCC's members signature to endorse ISS	APR_ICC Signatures.pdf **Date/Time:** 31.05.2011 11:09:24 **Size:** 3 MB		
4	**File Type:** Minutes of ICC meetings in 2010 * **File Desc:** ICC meeting to endorse APR 2008 and 2009	**File name:** MINUTE_ICC MEETING YEAR 2010.doc **Date/Time:** 09.05.2011 19:46:13 **Size:** 30 KB		
5	**File Type:** Signatures of members of HSCC * **File Desc:** This file is not up load, since the HSS is not yet submit in this time	**File name:** HSCC signature to endorse APR of HSS.doc **Date/Time:** 31.05.2011 13:49:28 **Size:** 24 KB		
6	**File Type:** Minutes of HSCC meetings in 2010 * **File Desc:** Minutes meeting of HSCC juring 2010	**File name:** MINUTES_MEETING OF HSCC YEAR 2010.doc **Date/Time:** 09.05.2011 12:23:26 **Size:** 58 KB		
7	**File Type:** Minutes of HSCC meeting in 2011 endorsing APR 2010 * **File Desc:** Minutes of HSCC meeting to endorse ISS and CSO	**File name:** MINT-MEETING HSCC 12 Mei.doc **Date/Time:** 31.05.2011 13:19:32 **Size:** 50 KB		
8	**File Type:** Financial Statement for ISS grant in 2010 * **File Desc:**	**File name:** Financial Statement ISS.pdf **Date/Time:** 31.05.2011 11:00:34 **Size:** 3 MB		
9	**File Type:** Financial Statement for CSO Type B grant in 2010 * **File Desc:**	**File name:** Financial Statement CSO Type B.pdf **Date/Time:** 31.05.2011 11:00:34 **Size:** 5 MB		
10	**File Type:** Summary on fund utilisation of CSO Type A in 2010 **File Desc:** Financial Statement for CSO Type A grant in 2010	**File name:** Financial Statement CSO Type A.pdf **Date/Time:** 31.05.2011 11:00:34 **Size:** 1 MB		
11	**File Type:** EVSM/VMA/EVM report **File Desc:**	**File name:** EVSM Report Year 2010.doc **Date/Time:** 09.05.2011 13:17:09 **Size:** 50 KB		
12	**File Type:** other **File Desc:** APR CSO Type A section	**File name:** CSO TYPE A_APR 2010_FINAL.doc **Date/Time:** 16.06.2011 19:36:18 **Size:** 98 KB		
13	**File Type:** other	**File name:** The approval of HSS reprograming and late		

ID	File type Description	File name Date and Time Size	New file	Actions
	File Desc: The note of late submission of APR - HSS	submiting of APR HSS.doc **Date/Time:** 16.06.2011 07:38:27 **Size:** 28 KB		
14	**File Type:** new cMYP starting 2012 **File Desc:** cMYP from 2010 until 2014	**File name:** cMYP- ENGLISH 28 May_rev.doc **Date/Time:** 29.05.2011 03:17:23 **Size:** 2 MB		
15	**File Type:** other **File Desc:** The APR of CSO component Type B	**File name:** CSO TYPE B_APR 2010_FINAL.doc **Date/Time:** 16.06.2011 19:36:18 **Size:** 258 KB		
16	**File Type:** New Banking Details **File Desc:**	**File name:** New Banking Details.pdf **Date/Time:** 31.05.2011 03:39:13 **Size:** 3 MB		
17	**File Type:** Signatures of members of HSCC * **File Desc:** Signatures-CSO Report Endorsement	**File name:** APR_CSO Signatures.pdf **Date/Time:** 31.05.2011 11:18:55 **Size:** 3 MB		
18	**File Type:** External Audit Report (Fiscal Year 2010) for ISS grant **File Desc:** The external audit report (fiscal year 2010) for ISS, CSO and HSS grant	**File name:** Auditor Opinion - GAVI 2010.doc **Date/Time:** 16.06.2011 07:47:12 **Size:** 55 KB		
19	**File Type:** Financial Statement for HSS grant in 2010 * **File Desc:** We will produce the financial statement along with APR of HSS	**File name:** The approval of HSS reprograming and late submiting of APR HSS.doc **Date/Time:** 16.06.2011 19:38:20 **Size:** 28 KB		
20	**File Type:** other **File Desc:** HSS documents - September submission	**File name:** Indonesia.zip **Date/Time:** 05.09.2011 07:53:36 **Size:** 1014 KB		