GAVI Alliance

Annual Progress Report 2011

Submitted by

The Government of

Indonesia

Reporting on year: **2011**
Requesting for support year: **2013**
Date of submission: **9/5/2012 4**

Deadline for submission: 5/22/2012

Please submit the APR 2011 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

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

Note: *You 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/country/

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 the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) 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 APR, 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 languages of the arbitration will be English or French.

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: **2011**

Requesting for support year: **2013**

1.1. NVS & INS support

There is no NVS or INS support this year.

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2011	Request for Approval of
ISS	Yes	ISS reward for 2011 achievement: N/A
HSS	Yes	next tranche of HSS Grant Yes
CSO Type A	Yes	Not applicable N/A
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 is available here.

2. Signatures

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.

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**	Ayu Sukorini (Acting Director of Funds, Ministry of Finance)
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Theresia Sandra Diah Ratih, MHA	EPI Manager	+62214257044	tsandra_dratih@yahoo.co.id
Muhani, SKM, M.Kes	Chief of Community Participation, Center for Health Promotion	+62215203873	hani_sis09@yahoo.co.id
Tiodora Sidabutar	HSS Coordinator	+62215214884	setgavihss@gmail.com

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

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

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.

Name/Title	Agency/Organization	Signature	Date

ICC 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:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), 14 May 2012 , 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.

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.

Name/Title	Agency/Organization	Signature	Date
Ratna Rosita	Secretary General of MoH		
Bardan J. Rana	WHO		
Marisa Ricardo	UNICEF		
Dr. M. Shahjahan	WHO		
Yosi Diani Tresna	BAPPENAS (NATIONAL DEVELOPMENT PLANNING BODY)		
Martha I.	BAPPENAS(NATIONAL DEVELOPMENT PLANNING BODY)		
Dessi Ampuan	KWARNAS (SCOUT MOVEMENT)		

Dedi Kuswenda	Director of Basic Health Services, MoH		
Azizah Aziz	Consortium		
Tuminah W.	PP IBI (MIDWIVE SOCIETY ORGANIZATION		
Susi Subekti	TP PKK (Women Movement Organization)		
Laode Musafi	PKLN (FOREIGN AFFAIRS CENTER, MoH)		
Lily S. Sulistyowati	Chief of Center of Health Promotion, MoH		
Muhani	Center of Health Promotion, MoH		

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

Name/Title	Agency/Organization	Signature	Date
1. Azizah Azis	1. Consortium (Muslimat NU)		

2. Felix	2. Consortium (PERDHAKI)		
3. Atika	3. Consortium (Aisyiah)		
4.Tuminah Wiratnoko	4. Indonesian Midwives Association (IBI)		
5. Susi Soebekti	5. Family Welfare Movement (TP-PKK)		
6. Joedyaninngsih SW	6. Indonesian Scout Movement (Pramuka)		

2.4.2. CSO report endorsement

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

Name/Title	Agency/Organization	Signature	Date
1.Azizah Azis	1. Consortium (Muslimat NU)		
2.Tuminah Wiratnoko	2. Indonesian Midwives Association (IBI)		
3. Susi Soebekti	3. Family Welfare Movement (TP-PKK)		
4. Joedyaninngsih SW	4. Indonesian Scout Movement (Pramuka)		

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 2011 and specifies the requests for the period of January – December 2013

Sections

4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	4,538,102	0		0		0		0		0
Total infants' deaths	122,030	0		0		0		0		0
Total surviving infants	4416072	0		0		0		0		0
Total pregnant women	4,991,912	0		0		0		0		0
Number of infants vaccinated (to be vaccinated) with BCG	4,311,197	0		0	4,501,757	0	4,568,838	0		0
BCG coverage	95 %	0 %		0 %	95 %	0 %	95 %	0 %		0 %
Number of infants vaccinated (to be vaccinated) with OPV3	3,974,465	0		0	4,136,883	0	4,198,522	0		0
OPV3 coverage	90 %	0 %		0 %	90 %	0 %	90 %	0 %		0 %
Number of infants vaccinated (to be vaccinated) with DTP1	4,195,269	0	0	0	3,447,402	0	2,099,261	0		0
Number of infants vaccinated (to be vaccinated) with DTP3	4,195,269	0		0	3,447,402	0	2,099,261	0		0
DTP3 coverage	95 %	0 %		0 %	75 %	0 %	45 %	0 %		0 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	0	0	0	0	0	0	0		0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00		1.00
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	3,974,465	0		0	4,136,883	0	4,291,823	0		0
Measles coverage	90 %	0 %		0 %	90 %	0 %	92 %	0 %		0 %
Pregnant women vaccinated with TT+	3,993,530	0		0	4,170,054	0	4,232,188	0		0
TT+ coverage	80 %	0 %		0 %	80 %	0 %	80 %	0 %		0 %
Vit A supplement to mothers within 6 weeks from delivery	0	0		0	0	0	0	0		0
Vit A supplement to infants after 6 months	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	0 %		0 %	0 %	0 %	0 %	0 %		0 %

*

** 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 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011.** The numbers for 2012 - in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

  After calculating the results of the year 2010 population census, the target of children under 1 years old in 2011 had been changed from 4,538,102 (as shown on APR 2010) to 4,600,582, although this is still less than the target from administrative reported that is 4,761,912. Usually the government (issued by the Secretary General) target used to calculate/estimate the logistic needed of either vaccine, Safety Box, and ADS, while the administrative target used to review the performance of immunization services as in JRF as attached.

- Justification for any changes in **surviving infants**

  Indonesia still use births as the denominator for infant immunization in 2011, because the Central Statistic Body (Badan Pusat Statistik – BPS) only have IMR by province level and the number is not well known by district officers, so the number of surviving infants cannot be counted by districts. But, for 2012, we already committed yet with provinces and districts to apply this number of surviving infants as target of infant immunization.

- Justification for any changes in **targets by vaccine**

  There is no changes

- Justification for any changes in **wastage by vaccine**

  There is no changes

5.2. Immunisation achievements in 2011

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 2011 and how these were addressed:

Based on the administrative reports in 2011, Indonesia has achieved the target of BCG, HB birth dose, OPV3,and Measles as stated in the APR of 2010 (coverage of BCG : 97%, HB birth dose :80%, OPV3 : 93%, DPT-HB3: 94% and Measles : 92%). 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.

To bridge the competency disparity between the regions in the decentralization era, have been conducted several things such as Mid Level Manager (MLM) training, EVSM (Effective Vaccine Storage Management) and DQS (Data Quality Self Assessment) standardization,cold chain management training performed both at national and local levels. Even some of the areas did up to health center level. Following training activities, we conducted mentoring especially for the lower performance areas and the areas with new immunization staff.

New issues as a barriers to achieving immunization targets is growing rejection of the immunization services related to the issue of halal vaccines.This is addressed with the establishment of immunization advocacy and socialization teams that involve religious organizations, professions, educational institutions and NGOs that have interest to the health of children. Also conducted road shows to the troubled areas to improve the socialization skills of the regional teams and to disseminate the information for wider community. This activities supported by HSS reprograming at their 5 provinces, ISS remaining fund, also from country budgeting.

WHO also help with Media workshops, that has been conducted for journalists from printing and electronic media, especially in the 17th provinces that in 2011 to campaign against measles and polio, to increase their awareness of the importance of immunization. In the year 2011 has also conducted High Level Manager (HLM) to remind policy holders in all provinces, namely the Governor, Chairman of Local Parliament and Chairman of Local Planning and Budgeting Body, their obligation to implement the immunization services in their respective area, which is associated with South East Asia Regional commitment that Year in 2012: Year Intensification of Routine Immunization.

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

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **no, not available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate

How have you been using the above data to address gender-related barrier to immunisation access?

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

What action have you taken to achieve this goal?

We plan to change all the recording and reporting format with gender based at 2012, and introduce RR specific by name and ID in several provinces.

5.4. Data assessments

5.4.1. 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 still a difference between the administrative report and the coverage reported by other sources such as Riskesdas 2010, WHO/UNICEF estimate and Official Estimate. This will always occur before the recording/reporting individual based implemented in all regions.

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **Yes**

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

In 2010, Data Quality Self Assessment hadbeen 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. In 2011, we conducted DQS at 7 Provinces (North Sumatra, Bangka Belitung, Banten, North Maluku, East Nusa Tenggara, West Sulawesi, and West Papua) covering 14 districts, 28 Health Centres and 66 villages. *The results shown at the graphs below.*

Graph 1:Accuracy DTP-HB3 at Village Levelcompared to Health Centre, in 2010

Graph 1:Accuracy DTP-HB3 at Village Level compared to Health Centre, in2011

Graph 2: Accuracy of DPT-HB3 at Health Centrecompared to District Level, in 2010

Graph 2: Accuracy of DPT-HB3 at Health Centrecompared to District Level, in 2011

Graph 3: Accuracy ofDPT-HB3 at District comparedto Provincial Level, in 2010

Graph 3: Accuracy of DPT-HB3 at Districtcompared to Provincial Level, in 2011

The assessmentwas on the accuracy of DTP-HB3 and measles absolute coverage at province,district and health centre level. This graphs has shown that there are still found not accurate data at all levels.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

To improve administration data, there are activities conducted to improve data:

1. Indonesia has been started to introduced one identity number for all citizen, the gradual introduction started at capital city of selected provinces.

2. We introduced new RR tool based on individual specific code that will be generated by web, so we could avoid double counted and imported babies from other areas.

3. While doing DQS, we used this occasion as on the job training to province, district and health centre staffs, also for cadres at Posyandu how to do proper recording and reporting.

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

Expanded the web based RR to other provinces, conduct DQS as monitoring tool regularly, conduct coverage survey by district level

- Revised RR format for each administration level and used this form for all administration levels.
- Developing a tool that is web-based immunization report. This tool has been tried in 5 districts in Yogyakarta province.
- Conducted DQS as monitoring tools on regular basis.

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** and **Table 5.5b** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 11439.96	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	**Expenditure Year 2011**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**-**	**-**	**-**
Traditional Vaccines*	45,855,349	45,855,349	0	0	0	0	0	0
New and underused Vaccines**	0	0	0	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	4,981,627	4,981,627	0	0	0	0	0	0
Cold Chain equipment	1,757,704	1,757,704	0	0	0	0	0	0
Personnel	72,378	72,378	0	0	0	0	0	0
Other routine recurrent costs	509,125	255,927	157,919	46,694	48,585	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	12,393,453	12,145,022	0	75,682	172,749	0	0	0
-		0	0	0	0	0	0	0
Total Expenditures for Immunisation	65,569,636							
Total Government Health		65,068,007	157,919	122,376	221,334	0	0	0

* 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 state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

In 2011, almost all the funds (90%) that was allocated already used.

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

There was no underfunded.

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

All of traditional vaccines were funded by government.

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	21,771,676	27,551,372
New and underused Vaccines**	23,297,670	37,178,714
Injection supplies (both AD syringes and syringes other than ADs)	4,390,720	9,273,196
Injection supply with syringes other than ADs	0	0
Cold Chain equipment	1,509,131	8,492,125
Personnel	79,616	87,577
Other routine recurrent costs	507,899	558,689
Supplemental Immunisation Activities	0	0
Total Expenditures for Immunisation	51,556,712	83,141,673

* 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.

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

As experience from previous years, we are expecting to receive all funds that were budgeted for 2012 Especially for cold chain equipment as a EVM assessment 2011 result, we should replace some equipment at health centre,district and provinces level. We expect the changes will take 3 years.

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

Yes. The reason is same with the answer of 5.5.4 question.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 calendar year? **No, not implemented at all**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

If none has been implemented, briefly state below why those requirements and conditions were not met.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **0**

Please attach the minutes **(Document N°)** from all the ICC meetings held in 2011, 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 5.5 Overall Expenditures and Financing for Immunisation

ICC has been already merged with HSCC since 2011

Are any Civil Society Organisations members of the ICC? **No**

If Yes, which ones?

List CSO member organisations:

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for 2012 to 2013?

To achieve high coverage to be sustained, EPI should have strong commitment to provide well and closer services to community so that it is important to establish a stronger and more representative civil society constituency for immunization. Strengthening the capacity of the health system to minimize the“bottleneck” barriers in each level is a critical issue too, support from donors and CSOs will help the MOH over come the problem.

The comprehensive Multi-Year Plan (cMYP) for the National Immunization Program (NIP) or the National Action Plan has been developed for 2010-2014 in line with Strategic Plan of MOH, its vision and mission.

The National Immunization Program set up the goal and objectives that focusing on the following priority targets:

- To achieve UCI village 95% in 2013 and 100% by the end of2014.
- To achieve 80% or more of HepB Birth dose (HB 0 fornewborn < 7 days) coverage by 2014 to reduce
  - To increase coverage of measles second dose > 95% at primary school age to achieve the target: reducing 95% mortality death caused by measles complication compared by year 2000
  - To achieve polio eradication
- To validate achievement of Maternal and Neonatal Tetanus Elimination/MNTE (prevalence < 1/1.000live births)
- To maintain the use of AD syringes 100%.
  - To develop and implement national policy on waste management.
  - To introduce new vaccines (Hib, JE and Pneumococcal vaccines).

Are they linked with cMYP? **Yes**

5.9. 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 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011
BCG	Auto Disable Syringe 0.05 ml	GoI
Measles	Auto Disable Syringe 0.5 ml	GoI
TT	Auto Disable Syringe 0.5 ml	GoI
DTP-containing vaccine	Auto Disable Syringe 0.5 ml	GoI
Td	Auto Disable Syringe 0.5 ml	GoI
DT	Auto Disable Syringe 0.5 ml	GoI
HB Birth Dose	Pre-filled Auto Disable Syringe 0.5 ml (sing dose)	GoI
BCG and Measles diluent	Auto Disable Syringe 5 ml	GoI

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?

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. But, in some area, local government have still faced obstacles in providing of trained health workers and issue of high turn over of un-trained health workers . At the moment, GoI has conducted training followed by supervision to ensure safe injection practices. Also, we carried-out for safe injection into pre-service training for all new doctors, midwives and nurses before they assigned as government employment. We also reviewed the curriculum to ensure that every graduated doctors, midwives and nurses have knowledge and skill about immunization including safe injection practices.

Please explain in 2011 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 sharp waste management based on their facilities such as: incinerator, needle cutter, Pinhole, open burning followed by closed dumping,or burial etc.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	0	0
Remaining funds (carry over) from 2010 *(B)*	287,584	3,289,951,280
Total funds available in 2011 *(C=A+B)*	287,584	3,289,951,280
Total Expenditures in 2011 *(D)*	157,918	1,806,582,769
Balance carried over to 2012 *(E=C-D)*	129,666	1,483,368,511

6.1.1. 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.

Based on the Minister of Finance Decree No. 191/PMK.05/2011 about Grant Management Mechanism, so GAVI grant should be approved by Country General Treasurer. GAVI grant for 2011 has been approved. The approving steps were :
1. Proposing register from MoH to MoF
2. Proposing for approval of opening grant account
3. Adjustment funding allocation in DIPA (Daftar Isian Perincian Anggaran = Detail Budgeting List)
4. Directly Grant approval in terms of money and expenditure

As mentioned in table "Report on the use of ISS funds in 2011", the balance carried over to 2012 is IDR 1,483,368,511, in actually the balance amount is IDR 1,350,752,272. This is because there was an expenditure in 2009 (IDR 132,616,238) that not yet verified by BPKP (Badan Pemeriksa Keuangan Pemerintah = Government Finance Auditor)

6.1.2. 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

In 2011, the ISS funds came from 2010 balance carried over and it was used only for central level.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

Major activities that has been conducted to strengthen immunization using ISS funds in 2011 were :
1. National Meeting, attended by all provinces to evaluate program achievement for 2010 and developed planning for 2011
2. Supportive Supervision at 16 bad performance provinces by assisted them to develop follow up plan/PoA to improve their performance
3. Training of LAM (Local Area Monitoring), planning and budgeting and TT. This activity attended by all provincial immunization manager to build up their capacity on immunization management.
4. IRI (Intensification on Routine Immunization) year 2012 information and socialization campaign in central level. This was attended by all inter-program and stakeholders that involved in immunization services. The purpose was to get commitment and supports from them on immunization program.
5. Developing guidelines as a references for immunization officer at all level that were : Health Minister Decree for Immunization Services Guideline, supervision checklist for school based immunization and GAIN UCI, and a book about The Success of Immunization Program in Indonesia.
6. Management supporting included maintenance of facilities and official equipment.

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

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2011 calendar year (Document Number) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **Yes**

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

6.3. Request for ISS reward

Request for ISS reward achievement in Indonesia is not applicable for 2011

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

Indonesia is not reporting on New and Under-used Vaccines Support (NVS) fund utilisation in 2012

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	**Total doses for 2011 in Decision Letter**	**Total doses received by 31 December 2011**	**Total doses of postponed deliveries in 2012**

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)
- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

If **Yes**, how long did the stock-out last?

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced		
Phased introduction		
Nationwide introduction		
The time and scale of introduction was as planned in the proposal? If No, Why ?		

7.2.3. Adverse Event Following Immunization (AEFI)

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2011 (A)		
Remaining funds (carry over) from 2010 (B)		
Total funds available in 2011 (C=A+B)		
Total Expenditures in 2011 (D)		
Balance carried over to 2012 (E=C-D)		

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

Please describe any problem encountered and solutions in the implementation of the planned activities

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

Please attach:

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for for delay, if any

If yes, provide details

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

Indonesia does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Indonesia does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2012

Renewal of multi-year vaccines support for Indonesia is not available in 2012

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes

7.11. Calculation of requirements

8. Injection Safety Support (INS)

Indonesia is not reporting on Injection Safety Support (INS) in 2012

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2011**. All countries are expected to report on:

   a. Progress achieved in 2011

   b. HSS implementation during January – April 2012 (interim reporting)

   c. Plans for 2013

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before **15th May 2012**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2012, the HSS reports are expected by GAVI Alliance by September 2012.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve the revised budget and activities.**Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval. The changes must have been discussed and documented in the HSCC minutes (or equivalent).**

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2011

   b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2011 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2011 and request of a new tranche

9.1.1. Report on the use of HSS funds in **2011**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **3722090** US$

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)		7961000	16866397			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)					229759	
Total funds received from GAVI during the calendar year (*A*)		7691000	270000			
Remaining funds (carry over) from previous year (*B*)			6443193	6379889	2650174	
Total Funds available during the calendar year (*C=A+B*)		7691000	6713193	6379889	2650174	
Total expenditure during the calendar year (*D*)		0	333304	3729715	1537530	
Balance carried forward to next calendar year (*E=C-D*)		7691000	6379889	2650174	1112644	
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	3722090

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)		75629420390				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)					2605430150	
Total funds received from GAVI during the calendar year (*A*)		73064452500	3061743300			

Remaining funds (carry over) from previous year (*B*)		0	73064452500	72346598901	30052415079	
Total Funds available during the calendar year (*C=A+B*)		73064452500	76126195800	72346598901	30052415079	
Total expenditure during the calendar year (*D*)		0	3779596899	42294183822	17435265146	
Balance carried forward to next calendar year (*E=C-D*)		73064452500	72346598901	30052415079	12617149933	
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	3402734507

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January		9499.99	11339.79	11339.79	11339.79	
Closing on 31 December		9499.99	11339.79	11339.79	11339.79	

Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 9)**

If any expenditures for the January April 2012 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 22)**

Financial management of HSS funds

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS 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 HSCC in this process.

- After the endorsement of HSCC members, GAVI HSS funds was transferred from the Directorate General of Disease Control and Environmental Health to the Secretariat of Directorate General of Nutrition, Maternal and Child Health's BNI account number (a state owned bank).
- Mechanism of transferring funds from DG of Disease Control and Environment Health's bank account to Secretariat of DG of Nutrition and Maternal and Child Health was stated by the Decree of Director General of Disease Control and Environment Health as well as in case of revision.
- Transferring mechanism of GAVI HSS funds is as follows:

1. The Min. of Finance approved the budget of Secretariat of Directorate General of Nutrition, Maternal and Child, formally known as State Budget Document. This means that all expenditures used by GAVI project follow the State Financial Mechanism and the State audit,
2. Directorate General of Disease Control and Environmental Health transferred the fund to Secretariat of Directorate General of Nutrition and Maternal and Child Health's account number.

- In terms of transferring fund from central level to regional levels, MOH uses the Secretariat of Directorate General of Nutrition and Maternal and Child Health's bank account which has been registered and endorsed by the Ministry of Finance. Funds from central level are transferred to the Provincial Health Office (PHO)'s account number. The PHO transfers the funds to the District Health Office (DHO) bank account. The Implementing Units at central level, PHOs/DHOs, and the head of PHOs/DHOs are required to sign letter of integrity pact prior to receiving funds.
- The 2011 unit cost is used according to the cost standard from Ministry of Finance (Ministry of Finance Decree No : 100/PMK.02/2010)

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 26)

9.2. Progress on HSS activities in the 2011 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2011 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2011**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective 1: Community mobilized to support MCH			
1.1 Assesment and mapping of existing situation re	Village Mapping and Service Availability Mapping	80	Survey, MoH (DG of Nutrition and Maternal and Child Health)
1.2 Selection of cadres (CHWs) within their own co	- Cadres training of poskesdes (village health post), religious leaders in birth preparation and complication readiness (BPCR), and MCH handbook - Increased ability of cadres About Maternal and neonatal Health in Effort to Increase Immunization Coverage	95	DHO, PHO, DG of Nutrition and Maternal and Child Health, Health Promotion Center

1.3 Development, procurement and distribution of I	1. Printing of Guideline of Child Health Care for Cadre 2. Printing of Essential Neonatal Health Care Books 3. BPCR Campaign	100	1&2 : MoH (Directorate of Child Health) 3.DHO, PHO, MoH (Directorate of Maternal Health)
1.4 Sensitization of community and religious leade	Socialization to religious leaders in birth preparedness and complication readiness (BPCR),and MCH handbook	99	DHO, PHO, MoH (Directorate of Maternal Health)
Objective 2 : Management capacity of MCH personnel			
2.1 Needs assessment by MoH/ PHO/ DHO staff of MCH	Maternal perinatal Review focusing on neonatal death related to neonatal tetanus and KIPI (adverse event following immunization) in district.	99	PHO, MoH (Directorate of Child Health)
2.2 Advocacy by MoH/PHO staff to district administ	Advocacy meeting with the Provincial – related Sectors of the District / Municipal Strengthening Program for MCH and Immunization in 3 provinces (Banten, West Java, South Sulawesi).	33	PHO, MoH (Directorate of Surveilance and Immunization
2.3 Development and distribution of management gui	Printing of GAVI HSS information books	100	MoH (Secretariate General of Nutrition and MCH)
2.4 Plan, design and conduct training of district	- Training of district team on the integrated management of childhood illness including young infant, to avoid missed opportunity immunization at birth - Orientation of BPCR, danger sign, midwife TBA partnership, MCH handbook, Vit K1 injection, cohort implementation, MCH local area monitoring (PWS) for providers - Orientation of M & E Integrated Tools for district staff - Review the Implementation of IMCI Training	100	DHO, PHO, MOH (Directorate of Child Health)
2.5 The health centre team training in micro plann	Technical Orientation on MCH Regulation Janpersal Vaccination, MCH handbook for Health Center and team midwives	100	DHO, PHO, MoH (Directorate of Maternal Health)
Objective 3: Partnership formed with non-governmen			
3.1 Identification of partners, development of act	- Identification of partners, development of action plans, formulation of MOUs - Evaluation of Sector Partners in MCH Service Delivery in 5 Province (central level) - Coordinative Meeting to Strengthen the Implementation at Central Level	90	DHO, PHO, MoH (Directorate of Maternal Health)

3.2: Strengthening coordination, implementation of	- Strengthening implementation of MOU joint monitoring meeting - Orientation & Socialization of MCH Policy to the IBI (Indonesian Midwife Organization) in 5 Provincies,33 District/cities - Orientation on Providing Midwife - TBA partnership in 5 Provinces, 33 Districts/cities - Regular Meeting of CSOs group on Community mobilization and service delivery efforts - Regular Meeting of Midwives and TBAs at Health Centre Level - Regular Meeting of Midwives and TBAs at Village Level - Technical orientation on midwife - TBA Partnership for Health Centers Team and Community Midwifes - Two monthly regular meeting between Community, Midwives and TBAs at Health Center	90	MoH (Directorate of Maternal Health)
3.3: Engaging private sector partners in MCH servi	- Workshop For District/Cities CSOs Group - Advocacy and facilitation to engage Private Sector in MCH service Delivery in 5 Provinces - Evaluation for sector partners in MCH service delivery at Provincial Level	100	DHO, PHO, MoH (Directorate of Maternal Health)
Objective 4: Operational research on critical barr			
4.1: Pilot project on contracting health service p	Pilot project on contracting health service provision for under-served locality in Papua	0	MoH (Secretariate General of Nutrition and MCH)
4.2: Operational research on incentives for cadres	Operational research on incentives for cadres and salaried staff of health centre.	0	The activity will conduct in 2013 as approved in GAVI HSS's reprogramming
Support Cost			
	Management costs		DHO, PHO, MOH (Secretariate General of Nutrition and MCH)

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
1.1 Assessment and mapping of existing situation r	
	The purpose of Village Mapping and Service Availability Mapping was as follows: 1. To get an overview and evaluate activities related to MCH and immunization in villages of Banten province, West Java province, South Sulawesi province, Papua province, and West Papua province 2. To get an overview and evaluate the management of MCH and immunization programs in selected Health Centers of Banten province, West Java province, South Sulawesi province, Papua province, and West Papua province. 3. To get an overview and evaluate the availability of facilities associated with the MCH and immunization in villages of Banten province, West Java province, South Sulawesi province, Papua province and West Papua province. Respondents: Survey was carried out in 5 Provinces, covering 62 districts / cities, 1.588 Health Centers, 11 098 villages, (West Java

province, Banten province, South Sulawesi province, Papua province, and West Papua province).
The survey was carried out by Universities at respective provinces: Padjadjaran University(West Java Province), University of Indonesia (Banten province), Hasanuddin University (South Sulawesi province), Cendrawasih University (Papua and West Papua)
a. In 2010 the activities ranged from the preparation through the implementation of the survey as well as village mapping. The progress achieved in 2010 are as follows:
b. Qualitative Data (Village Mapping) were analyzed from 10.352 villages (West Java: 5,893, Banten: 1.532, South Sulawesi: 2,319 Papua: 185 and West Papua: 423)
c. Qualitative data were collected by doing in-depth interviews to 125 respondents (West Java: 78 respondents; Banten: 24, and South Sulawesi: 23). Papua and West Papua had not been able to collect the qualitative data due to time constraints and geographical problems. They started doing it in early 2011.Service Availability Mapping (SAM) was conducted to identify the position of local government hospitals and medical centers in 62 districts.
In 2011, the survey contained data analysis and dissemination of results as the following:
1. The overview Mapping of the average community mobilization at GAVI provinces:
a. The average number of Posyandu in each village : Banten : 6, West Java : 8, South Sulawesi : 3, Papua : 1, West Papua : 3
b. The percentage of villages that have operating funds for Posyandu : Banten : 42%, West Java : 49, South Sulawesi : 39%, Papua : 31%, West Papua : 30%
c. Main source of MCH funding in villages Banten : 62%
d. The percentage of villages that have registry :
- Pregnant women (Banten : 95%, West Java : 99%, South Sulawesi : 97%, Papua : 35%, West Papua : 88%)
- Neonatal (Banten ; 98%, west Java : 99%, South Sulawesi 98%, Papua : 38%, West Papua : 94%)
- Childhood (Banten : 98%, West Java : 99%, South Sulawesi : 97%, Papua : 57%, West Papua : 95%)
e. The percentage of villages whose pregnant women have MCH booklet (Banten : 88%, West Java : 72%, South Sulawesi : 81%, Papua : 25%, West Papua : 82%)
f. The percentage of villages that have Poskesdes (village healthcare post) : Banten : 34%, West Java : 36%, South Sulawesi : 77%, Papua : 7%, West Papua : 4%) and the Percentage of villages that have Polindes ; Banten : 13%, West Java : 22%, South Sulawesi : 22%, Papua : 4%, West Papua 1%

1.1.1 Village Mapping and Service Availability Map

2. SAM of midwife in the village:
a. The percentage of villages that have midwives ; Banten : 92%, West Java : 97%, South Sulawesi : 92%, Papua : 62%, West Papua : 52%
b. The percentage of midwives living in the village ; Banten : 80%, West Java : 87%, South Sulawesi : 66%, Papua : 32%, West Papua : 20%
c. The percentage of midwives who have immunization (Banten : 52%, West Java : 51%, South Sulawesi : 50%, Papua : 41%, West Papua : 33%), and the percentage of midwives who have IMCI (Banten : 18%, West Java : 21%, South Sulawesi : 26%, Papua : 32%, West Papua : 40%), and the percentage of midwives who have BPCR qualification (Banten : 62%, West Java : 51%, South Sulawesi : 55%, Papua : 50%, West Papua : 34%)
3. SAM for MCH programme:
a. The percentage of neonatal visit coverage ; Banten : 98%, West Java : 79%, South Sulawesi : 97%, Papua : 57%, West Papua : 80%
b. The percentage of complete neonatal visit coverage ; Banten : 98%, West Java : 76%, South Sulawesi : 82%, Papua : 59%, West Papua : 71%
c. The coverage of baby visit to the Health Center ; Banten : 98%, West Java : 73%, South Sulawesi : 97%, Papua : 98%, West Papua : 77%
d. The percentage of normal deliveries at Health Centers ; Banten : 73%, West Java : 76%, South Sulawesi : 87%, Papua : 87%, West Papua : 88%
e. The coverage of deliveries by skilled health personal ; Banten : 74%, West Java : 75%, South Sulawesi : 81%, Papua : 57%, West Papua : 66%
4. SAM Immunization:

	a. The HBO immunization coverage ; Banten : 97%, West Java : 88%, South Sulawesi : 96%, Papua : 49%, West Papua : 81% b. The DPT3 immunization coverage ; Banten : 88%, West Java : 86%, South Sulawesi : 92%, Papua : 85%, West Papua : 81% c. The Measles immunization coverage ; Banten : 87%, West Java : 82%, South Sulawesi : 91%, Papua : 72%, West Papua : 85% d. The percentage of Health Centers that have r refrigerator ; Banten : 92%, West Java : 72%, South Sulawesi : 74%, Papua : 51%, West Papua : 48% e. The percentage of Health Centers whose refrigerator functions properly ; Banten : 96%, West Java : 92%, South Sulawesi : 69%, Papua : 48%, West Papua : 44% 5. Health Center : 6. Hospital : 62 Public Hospitals Information utilization are for the following: 1. Data and information: used as data baseline planning for GAVI's 2ndtranche disbursement 2. As a data information for provinces and districts/cities to design a program in their respective areas, especially for the development of MCH and Immunization programs. 3. As a material for MCH and immunization advocacy to various programs at central level, provincial level, private sector, and CSO 4. As a material to determine a central and regional level policy 5. As a baseline for other health assessment activities The analysis result was disseminated in the following ways: 1. Dissemination to the cross program at the central, provincial, district level, as well as to the international partners. 2. Publication through the official website: www.gizikia.go.id 3. Printing out of books, distributed to the cross-program, cross-sector, international partners, as well as to GAVI HSS's provincial and district/city level

1.2 Selection of cadres (CHWs) within their own co	Health development in Indonesia is still characterized by high maternal mortality and infant mortality rate. The direct causes are hemorrhage, eclampsia, infections, etc.),whereas the indirect causes are delays in taking decisions, late referral, late handling, too frequent pregnancy, too young or too old pregnancy, and a too short interval between pregnancies. One important component of the health system that needs to be strengthened is a community empowerment through cadres by cadres trainings in order to reach the following: 1. Increase their knowledge and awareness in using MCH handbooks as well as on Birth Preparation and Complication Readiness (BPCR), increase the knowledge of cadres on infant health as well as type and schedule of immunization. Cadres are expected to contribute in disseminate information to the communities in taking care of the baby as well as type and schedule of immunization. 2. Increase their capacity about MCH in order to improve the immunization coverage that is expected to help health staff in observing post partum mothers, in helping mothers to initiate breast feeding, in baby's health, in preparing the target on immunization i.e.: community leaders, religious leaders, cadres, and health staff at each Health Center. In 2011, 5,352 cadres in 5 provinces were trained, as described below: 1. West Java Province:1,792 cadres in 8 districts. 2. South Sulawesi Province: 2,398 cadres from 6 districts 3. Banten province: 200 cadres in 5 districts 4. West Papua Province: 100 cadres in 2 districts. 5. Papua Province: 984 cadres in 3 districts. Problems in implementing the program: 1. West Java Province The activity was too temporary, and there was not enough fund support for post training activities, making the program uncertain to sustain. 2. South Sulawesi Province There were too many cadres to be trained whilst there was a shortage number of DHO and Health Center staff to give training, which made the trainings to be inefficient. 3. Banten province In Tangerang city, this training was unable to be done due to fund channeling regulation that the local authority applies
1.3 Development, procurement and distribution of I	

1.3.1 Printing of Guideline of Child Health	These books contain information on neonatal care, infant health, childhood care, management and treatment of asphyxia, infection in babies suffering low weight at birth, type and schedule of immunization, to be distributed and used during cadres training. Cadres are the closest to the community, so they have big role in campaigning health messages to the whole society. In order to support this role, there is a need of a guideline, including that of child health; so that cadres can give correct information about child health to the community, which at the end, they are motivated to give immunization to their children. Printing of Guideline of Child Health Care for Cadre 20.000 books have been printed and 15.234 have been distributed to the following provinces : a. West Java: 9.387 books b. Banten: 2.851 books c. South Sulawesi: 1.999 books d. Papua: 847 books e. West Papua: 150 books Books have not been distributed yet as some districts are due to conduct the activity. They will be distributed during 2012 training. As number of targeted cadres for getting training are still low, re-copying of booklets are necessary for cadre training.
1.3.2 Printing of Essential Neonatal Health Care B	These books are used by health staff working at primarily healthcare units for neonatal healthcare including Hepatitis B0 and BCG vaccine, as an effort to support an effective implementation of health care programs and accelerate a lowering of IMR rate, thus achieving MDG target and immunization program. The copying of this booklet funded by GAVI HSS budget, and its development funded by the state budget. 9,000 copies were distributed to 5 (five) GAVI provinces (Papua: 300 booklets, West Papua: 155 booklets, South Sulawesi: 1,725 booklets, Banten: 1,650 booklets, and West Java: 5170 booklets).
1.3.3 BPCR (Birth Preparedness and readiness Crite	BPCR campaign is carried out to reach healthy pregnant women, through the empowerment of their husband, their family, and the community. This model proves that women still need their male partner in improving health status. As a result, an improved coverage of delivery, maternity services, complication services, as well as referral services, is reached. BPCR campaign is expected to make people aware about the importance of planning their pregnancy and birth. This is done by introducing the BPCR program and to empower pregnant women and their families, using MCH book as the only source of pregnancy record as well as childhood record, so that the community and all components of nation can move along within the “Save Indonesia’s Mother” campaign. The title of the campaign is "Birth planning is the key to a safe and secure mother and baby". This is done by doing the following methods: 1. Mass examination of pregnant women coupled with BPCR and MCH booklet socialization 2. MCH issue coverage and its reviews in local print and electronic mass media 3. Installation of BPCR billboards, banners and posters Achievement in 3 provinces: 1) West Java province: 630 people participated in the campaign 2) Papua province: 343 people participated in the campaign 3) West Papua province: 205 people participated in the campaign
1.4 Sensitization of community and religious leade	

1.4.1 Socialization to religious leaders in birth	The objective of this activity is to establish good partnership between the religious leader/community leader with health provider on how to mobilize the community related to BPCR and the use of MCH handbook Through this activity the expected benefits are: 1. Collaboration of religious/community leader in the delivery of MCH and Immunization 2. Community mobilization through community religion in the delivery of MCH and Immunization. This activity has also resulted in a socialized BPCR and MCH book on religious leaders as well as community leaders as they are more involved in mobilizing and empowering the community to improve MCH program coverage, and also to help health staff in preparing the immunization target. One example of these religious leaders involvement is that the Ustadz (Islamic cleric), principal of Islamic boarding school, and Quran reading tutor are active in informing health issues, particularly MCH book, during religious gathering, reminding mothers of immunization schedules, giving guaranty about immunization that is “halal” (permitable in Islam), and to pursue every “alert husband” of their role. In 2011, 2,257community leaders and religious leaders were trained in 4 provinces: 1) Banten province: 760 cadres of community and religious leaders 2) South Sulawesi province: 869 community and religious leaders 3) Papua province: 649 community and religious leaders 4) West Papua province: 249 community and religious leaders Problem faced during the activity : Limitation of IEC material for community/religious leaders to develop MCH and immunization program
2.1 Needs assessment by MoH/ PHO/ DHO staff of MCH	
2.1.1 Maternal perinatal Review focusing on neonat	Coordinative meeting among responsible persons at central level who are in charge on MCH program, immunization program, health promotion program. The meeting is to create a concept on how to integrate the MCH and immunization program, starting from central level up to provincial/district level. The meeting also to integrate Birth Preparation Complication Readiness (BPCR), Maternal Child Health (MCH) handbook, Vitamin K1 injection, utilize MCH cohort at central level, including Training of Trainer (TOT) on BPCR modules, MCH handbook and vitamins. Series of activities include: 1) Reporting and tracking maternal and neonatal mortality cases as well as cases of adverse event following immunization, 2) Assessment for recommendations that must be followed to prevent the recurrence of cases of maternal and neonatal mortality. AMP implementation, in addition to the assessment of the causes of maternal and neonatal mortality, also analyzes the continuum of care through indicator analysis of health care programs, namely antenatal care, childbirth, postnatal care and infant immunization. The purpose of activities are: 1. To improve health center staff’s ability at provincial level on Maternal Prenatal Auditing 2. To improve the quality and sustainability of the implementation of AMP at provincial and district level Training activity was initially done for 26 facilitators from central level and 18 from provincial level, who were going to become TOT in their respective area. Achievement: 1) West Java province: 78 HC’s staff were trained 2) Banten province: 68 Health Center’s staff 3) South Sulawesi province: 254 Health Center’s staff This activity was not conducted in Papua province nor in West Papua province, due to limited number of TOT including pediatricians to give training.

2.2 Advocacy by MoH/POH staff to district administ	
2.2.1 Advocacy meeting among DHO, PHO, and local g	Various problems and challenges in the implementation of the immunization program in Indonesia are: • Low access due to geographical conditions • Disparities between regions • Availability of logistics • Frequent staff turnover resulting in loss of quality staff. • The absence of similarity between the target number of immunization and MCH • The existence of groups that refuse immunization associated with the issue halal vaccines. To overcome these problems there is a need of cooperation of a wide cross-sector and cross-linked programs through advocacy activities. Advocacy meetings were planed to only three provinces, namely West Java, Banten and South Sulawesi, considering that human resources in these three provinces are easy to implement and coordinate. The objective of activity is • To pursue local government to allocate a budget for MCH and immunization programs • To create a common understanding on the integrated MCH and immunization programs among those related stakeholders within MOH as well as inter cross-sector and cross-linked programs In 2011 only Banten Province that implemented this advocacy meeting, where South Sulawesi province will execute in 2012. Some recommendations resulted from the meeting to increase immunization coverage are: • A need to create training between MCH and Immunization. • A common source of immunization and MCH data targets. • A need of an advocacy immunization team at provincial level. • A need of a particular strategy to reach out isolated areas by involving a wide cross-sector and cross-linked program • A need to increase a role and participation of community leaders and religious leaders who refuse immunization in their area in order to strengthen community empowerment.
2.3 Development and distribution of management gui	
2.3.1 Printing of instrument to monitorGAVI HSS im	The GAVI HSS activities at central, provincial, and district/city levels are the authority of variety of units and programs, such as Maternal and Child Health Program, Immunization program, and Health Promotion Program, which make HSS activities varied. In order to easily monitor and implement these varied activities at each level, integrated tools were developed and distributed to be used at all levels. These integrated tools has been used to comply reports within the various level of implementing units from HC level/district/provincial level and central level. In 2011, 200 packages of integrated tools have been distributed to all GAVI HSS implementers.
2.4 Plan, design and conduct training of district	
2.4.1 Training of district team of integrated mana	The purpose of this activity is to improve knowledge and skills of health center staff. They are expected to have ability on how to examine, classify the symptom of illness, and treatment so they will confidence to immunize the baby due to clear classification of illness. They also have to check the status of immunization so they will contribute to increase the immunization coverage by avoiding a missed opportunity. The activity was started by a training of trainer at provincial level, who later on will be assigned to train district health staff, who then will train health center staff to be able to work in the community. The progress achieved : Total number of health center staff trained were 138, as follows : South Sulawesi province: 88 staff Banten province: 50 staff West Papua province and Papua province have not conducted this activity, as it was arranged at the same time with other Regional – funded activities.

2.4.2 Orientation of BPCR, danger sign, midwife –	The objective of this activity is to socialize among providers the importance of Birth Preparedness and Complication Readiness in the effort to accelerate the reduction of MMR. Through this activity, it is expected that the providers would be able to create community awareness to get services from skilled birth attendants, including immunization services at health facilities. 1,008 staff of District Health Office have been trained, in 2011 as described below: 1. West Java province: 378 staff 2. Banten province: 48 staff 3. South Sulawesi province: 360 staff 4. Papua province: 120 staff West Papua province: 102 staff
2.4.3 Orientation of M & E Integrated Tools for di	In 2011, the integrated tools for GAVI HSS implementation monitoring at all levels have been developed. In order to monitor the implementation of the activities. All responsible person on MCH and immunization program from district/provincial level were trained on how to utilize these tools. These tools are also useful to synchronize perceptions between implementers towards each of indicator's definition.
2.4.4 IMCI implementation review in provinces	This is a regular review of the Integrated Management of Childhood Illness (IMCI), reviewing its progress and evaluates the ongoing activities. This meeting is a revision of the community – based IMCI activity, as there was a need to evaluate IMCI implementations. Recommendations from the meeting: a. More IMCI socialization, where its implementations can increase the immunization coverage and lowering miss opportunity cases b. Strengthening recording and reporting system that could support IMCI services c. Monitoring and evaluating, including post training monitoring There is a need to continue workshops to guaranty the ongoing implementations and quality of IMCI services
2.5 The health centre team training in micro plann	

2.5.1 Orientation of BPCR, danger sign, midwife TB	The purpose of this activity is to improve midwives knowledge to give advocacy on Immunization for both mother and baby. In 2011, 1,920 were trained, described as follows: West Java: 630 midwives a. The improved midwife's ability who works at local hospitals, privately, and at the village, to perform BPCR, to administer Vitamin K1 injection, to apply cohort, Local Area Monitoring, and to use MCH book b. It has been decided that all midwives must apply cohort for mothers and babies and to make record of their application, and also to use MCH books right from ANC phase up to childhood age. South Sulawesi : 450 midwives After getting orientation, midwife and her partner are able to apply BPCR program, MCH book, to administer vitamin K1 injection, cohort book, and to do Local Area Monitoring. The problem found during the training was that: a. The number of stickers and MCH books were not enough for all targets b. Midwives did not submit their Local Area Monitoring report on time. Banten : 480 midwives The training was attended by all midwives where they were expected to understand about BPCR programs, MCH, and immunization. Papua: 161 midwives The trained midwives obtained BPCR programs, MCH book, danger signs, vitamin K1 injection, immunization, and cohort application, trained by obstetrician and gynecology specialist, so that they could get a basic understanding on how to handle pregnancy and its danger signs. Apart from midwives, the training was also attended by lecturers and students of three year midwifery school in Biak district, where they could learn about pregnancy and its danger signs. Papua Barat: 199 midwives Through this activity, cohort recording and its application for mothers and babies were agreed to be used as a basis of reporting at HC level. This cohort use is contained in MCH Local Area Monitoring book that had never been used in HC level. Supiori district and Jayapura city of Papua province have not yet implemented the activity, due to geographical problems.
2.5.2 Health centre team training in Management MC	The purpose of the management training is to improve Health Center's staff skill in implementing MCH services at Health Centers, particularly in giving immunization according to the standard, so that the efforts in health can be accomplished optimally. The district/city team who has been trained on point 2.4 will then provide training on MCH management for Health Center staff. In 2011, all of 107 targeted Health Center staffs have been given management training at districts/cities, described as following: a. West Java: 60 staff from 20 Health Centers b. Banten: 108 staff from 36 Health Centers c. South Sulawesi: 153 staff from 51 Health Centers in Gowa district, Maros district, and Takalar district Papua province has completed this activity in 2010, whereas West Papua province, due to limited number of DHO staff that capable for training In 2011, 411 Health Centers with staff have been trained.

2.5.3 Technical Orientation on MCH Regulation Janp	This activity very much supports Jampersal that covers: Antenatal Care, Infant and Neonatal Care, Post Neonatal Care and Family Planning, where all costs are covered by the government. This program is aimed to increase birth process at health facility by health staff, and to increase TT, HBo, and BCG immunization coverage, as well as to increase the number of private midwives who are willing to apply an MoU of Jampersal. Apart from the targeted individuals, there were other persons who attended this orientation meeting because of its importance. The achievements in 5 provinces are described as follows: West Java province: 280 midwives attended the orientation a. The meeting was also attended by private midwives b. Midwives were given information about Jampersal so that they could support it c. Pregnant women were encouraged to give birth at health facility d. HB0 and BCG immunization coverage e. Midwives were encouraged to use MCH book f. Community was encouraged to use MCH g. Continuum care including integrated HB0 and BCG immunization within 1st visit, 2nd visit, and 3rd visit program coverage h. TT immunization during pregnancy care (ANC) i. MCH and immunization registry reporting system was agreed to be done Banten province: 126 midwives attended the orientation The activity was also participated by 21 HCs and 72 private midwives. However, this activity was not able to be done in Tangerang city, where local authority obliged the fund to be inserted as Local District/City Budget South Sulawesi province: 190 coordinating midwives and HC immunization staff attended the orientation to understand the management and to support the MCH/immunization program, policy of Jampersal insurance, and MCH book for pregnant women. Papua: 40 private and HCs midwives attended the orientation to get orientation and Jampersal Insurance policy, so that these private midwives could increase birth coverage at health facility. During 4th visit to the health facility, it is expected that the mothers will receive TT immunization, and for the neonatal to receive HB0 immunization before they leave health facility. West Papua province did not conduct the orientation meeting as they were at the same time conducting a Regional – Budget activity.
3.1 Identification of partners, development of act	
	Partnership is cooperation between two parties or more, in a basis of equality, openness, and mutuality. Partnership on health should be based on a mutual understanding, mutual trust, the need to each other, close relation, assistance to each other, develop each other's potential, ability, strength, and mutual respect. The expectation of doing partnership with non government agencies such as : - An equal perception about health problems and how to tackle those problems with effective efforts among health providers and partners - Development MoU's and monitor the implementation of the MoU's Progress Meetings between PHO (MCH program officers, immunization program officers, and Health Promotion officers) and DHO to identify partnership, as described below: West Java Province Partners from 14 districts/cities were identified, consisting: Hospital Association, private/independent midwives, private hospitals, Practitioners Association, Pediatricians Association, Obstetrician and Gynecologist Association, and private companies (as contained in 2011 APR draft)

3.1.1 Identification of partners, development of a	The activities that were agreed to be in included in MoU: a. Private hospitals performed MCH services including neonatal basic immunization b. Private hospitals contributed fund for Posyandu (Integrated Health Post) c. Private and independent midwives gave basic immunization services and reported them to the local Health Center d. PT. Pupuk Kujang and PT. FCC contributed funds for 10 posyandus in each of their area as well as supplementary nutrition for malnutrition cases in Karawang district. e. PT KIIC and Toyota, each of them gave facilities for posyandus in five villages as well as supplementary nutrition for 17 posyandus in Karawang district f. Peruri gave ambulance to HC and constructed one polindes (Village Maternity Post) in Ciampel sub district g. PERTAMINA gave five units of incubator for 5 PONED HCs in Karawang district Banten Province Meeting between MCH program officers, immunization officers, and Health/Promotion officers of PHOs and DHOs to identify partnership with: a. White Ribbon Alliance, an NGO that works on maternal health and whose members are mothers, students, and female youths b. AISYIAH, an Islamic female organization that works on health c. PKK (Family Welfare Education, whose members are women at district to provincial level) d. PRAMUKA or boy scouts e. Professional organizations (IBI, IDI, POGI, IDAI) The MoU that regulates the partnerships with the above organizations is still being developed. However, some co works have been conducted, such as MCH socialization to decrease MMR and IMR South Sulawesi province The identified partners in 12 districts/cities of GAVI HSS areas are: AISYAH, Bunia Usaha, Fatayat NU, PKK, IBI/BPS, PT London Sumatra, Toyota, NV Haji Kalla, MUI, BKPRMI, Muslimat NU, Healthy District Forum, IDI, Universities, private/state high schools, district state hospitals, PT. Citra Cable, Maccopa boarding school, PT. Semen Bosowa, Radio Salewangan, Sindo, PT. Energi, Radio As'adiyah The MoU of partnership with those organizations and companies are still being developed. However, some cooperation's were realized as described below: a. MCH socialization to lower MMR and IMR b. Assistance to ease socialization activities c. Training for NU organization (Islamic organization) on community mobilization about MCH and immunization programs d. Activate Dasawisma (10 to 20 family groups) for cadres of "Family Welfare Education" group e. Increase immunization efforts and strengthen recording and reporting system by private midwives

3.1.2 Evaluation for Sector Partners in MCH Servic	The purpose of this activity is to improve knowledge and skills of health center staff. They are expected to have ability on how to examine, classify the symptom of illness, and treatment so they will confidence to immunize the baby due to clear classification of illness. They also have to check the status of immunization so they will contribute to increase the immunization coverage by avoiding a missed opportunity. The activity was started by a training of trainer at provincial level, who later on will be assigned to train district health staff, who then will train health center staff to be able to work in the community. The progress achieved : Total number of health center with staff have been trained : (West Java : 404, South Sulawesi : 24, Banten : 72, Total number of health center staff trained: 500 Constraints during the implementation in 2010 : In October and November, Wasior flood disaster emergency response was set up. Follow-up plan • Districts that have not yet implemented it in 2010 will do it in 2011 • Post-training will be monitored, to be implemented in 2011 by direct observation, using a valid facilitative supervision instrument.
3.1.3 Coordinative meeting to strengthen the imple	Coordinative meeting were conducted by central level twice. The objective of the meeting was to synchronize partnership activity at central level and at the provincial and district level. Some CSOs (Women Family Welfare, Midwife Organization, Pediatricians, Gynecologist) from central level were attended the meeting.
4.1 Pilot project on contracting health service p	This activity cannot be done in 2011. The constrain was : The funds disbursed by GAVI Geneva were in partial amount, whilst activities involving contracting out parties require an one package contract. However, in 2011 preparation has been done by engaging Technical Support Assistance from Gajah Mada University that been conducting assessments for Contracting Out Services for Maternal and Child Health and Basic Immunization in Pegunungan Bintang District of Papua Province, and in Raja Ampat District of West Papua Province
4.2 Operational research on incentives for cadres	The activity will be conducted in 2013 as approved in GAVI HSS's reprogramming
3.2 Strengthening coordination, implementation of	
3.2.1 Strengthening implementation of MOU joint mo	The meeting was conducted in province, and was attended by central level, province health officer, district health offices. Objectives are : 1) To develop the same perceptions of Partnership 2) To identify progress of partnership 3) To identify problems 4) To discuss problems solutions In general, the meeting conclusions are; 1) Partnership is important to support coverage improvement on MCH and Immunization services 2) Districts Health Office will conduct midwives and YBA partnership 3) MOU between Health sector and CSO is important 4) Partnership will support the existing CSR Potential problems : limitation of meeting schedule, limitations

3.2.2 Orientation & Sosialization MCH Policy to th	This meeting was conducted in central/ Jakarta, and was attended by central officer, province participants, districts a participants. Basically this meeting is to improve the collaboration, coordination between Health sector and IBI (Indonesia Midwives association), due to improve the MCH and immunization coverage Objectives are : 1) To increase the understanding of MCH and immunization improvement government policy 2) To improve the understanding concept of midwives and TBA partnership 3) To explore the possibility for conduct partnership
3.2.3 Orientation on Providing Midwife - TBA partn	central, province and districts health officer. Basically this meeting is to disseminate the midwives and TBA partnership concept, how to develop partnerships in order to increase the coverage of MCH and immunization services This meeting will be continued in the similar meeting in province Objectives are : 1. To increase the understanding of MCH and Immunization partnership concept 2. To explain the step to develop partnership 3. To identify the problem-solving 4. To discuss the follow-up Problems are : 1. There are midwives and TBA did not yet want to collaborate each other to help delivery in the field 2. TBA has strong confidence, they need several time to collaborate with midwives. 3. TBA live in the village that majority has difficult geography condition. 4. There are midwives who are not able to delivery yet Results of the meeting are : 1. Increasing of partnership knowledge 2. Increasing of stepping partnership development 3. Drafting of MOU 4. Composing problem solving developing partnership and improve guidance and monitoring.
3.2.4 Reguler Meeting CSOs group for Community mob	This reguler meeting was implemented in District, and was attended by participants from District Health Office and CSO's. Basically this meeting is to monitor the progress of CSO partnership in order to increase the coverage of MCH and Imunization services. This meeting has objectives : 1. To identify the progress of partnership activities which has been done by CSO's 2. To identify the problems 3. To discuss the alternatives solutions 4. To develop the follow up activities The number of participants from CSO's was : 1) West Java 100 persons. 2) Banten : 140 persons. Tangerang City did not conduct the activity because of local policy that all supporting budget from out side district has to apart of district financial management. The CSO's, for example : 3) South Sulawesi : 400 persons 4) Papua : 33 persons 5) West Papua : will conduct in 2012 In general the problems was : 1) The MOU did not yet develop 2) CSO budget limitations 3) CSO's activities reporting

3.2.5 Reguler Meeting Community Midwives and TBAs	This reguler meeting was conducted in subdistrict/ health center, and was attended by Health center and community midwives and TBA's. Basically this meeting is to monitor the midwivws and TBA partnership in health center level, in order to increase the coverage of MCH and immunization services. The objectives are 1) To improve the understanding of partnersip between midwives and TBA's 2) To identy the the progress of partnership 3) To identify the peroblems 4) To discuss the alternatives of solutions 5) To discuss the follow ups In general the tehnical expectations from the midwives and TBA partnership are : 1) The strengthening of work-collaborations and coordinations between midwives and TBA, due to improve the coverage of MCH and imunization services. 2) To lookfore and to agree the formed 3) Changing of TBA role from birth delivery to midwives partner in birth delivery and mother/ babies postnatal care 4) To improve the coverage of antenatal, delivery, postnatal services and imunizations The number of Health Center who had Regular Meeting Community Midwives and TBAs in 4 provinces was 121 HC from target 130 HC : 1) West java 30 HC 2) Banten 21 HC Tangerang city did not conduct this activity because of local poly, that all activity budgets not from local budget has to apart of local financial management system 3) South sulawesi 42 HC 4) Papua 25 HC 5) West Papua : will conduct the activity in 2012 The problems was : 1) There were so many TBA in the villages, in the other side there was limitations of activity budget. The solutions are to advocate the local goverment to activity budget support 2) TBA have strong self confidence, that they has difficulty to change their delivery role perceptions. 3) The difficulty of geography conditions make a communications problem 4) The low of TBA educations make a difficulty to be quick and easy understanding of new idea. 5) The low of TBA obedience make difficulty to folow the agreement

3.2.6 Reguler Meeting Community Midwives and TBAs	This meeting was conducted in the villages, and was attended by village/ community midwives and TBAs. Basically this meeting is to strengthen the partnership and monitor the progres of partnership activities due to improve the coverage of MCH and imunizations The objectives this meeting are : 1) To strengthen the midwives and TBAs partnership 2) To detect the number of pregnant mother who contact with TBAs 3) To identify the problem related with TBAs role in MCH support and community persuaded for MCH and Immunization receiption services 4) Discuss the alternative problems solutions The number of midwives who involve in this activity are : 1) West Java :150 persons 2) Banten : 35 persons Tangerang city did not conduct this activity because of channeling regulation that the local authority applies 3) South sulawesi : 300 persons 4) Papua : 45 persons 5) West papua will condut in 2012 This meeting is technical orientation that was conducted in Districts, Municipalities, and was attended by MCH, imunization and other related program holder in from District Health Office ond health center staf including head f Health center, health center Midwives, village/ community midwives. Basically this meeting is to explain the consept of village/ community and TBAs partnership, activities, how to develop partnership. The objective are : 1. To explain the concept of midwives and TBAs partnership due to increase the coverage of MCH and imunizations 2. To inform the step of how to build partnership : example : how to engage TBA to be a partner, development of action plan, development of MOU, Joint monitoring and evaluation 3. To identify activities to be implemented In general the results are : 1. Increasing of midwives and TBA partnership understanding on concept, stepping and activities. Due to increasing of MCH and imunization services. 2. Participants has agreed to follow up the result of meeting: e.i : develope of MOU, etc Problems is West Papua, Numfort District in Papua did not conduct the meeting because of limitation of remainning time and limitations of health staff as a fasilitator

3.2.7 Technical orientation on midwifes TBAs Partn	These meeting were conducted in District and was attended by District health officer, Health Center and village/ community midwives. These meeting is as continuations staff of Orientation community midwives and TBA's These meeting have similarity with orientation on providing midwife- TBA partnership in central level that has been attended by representative of the meeting's GAVI HSS province and distristrict. The Objectives are : 1. To inccrease the understanding of midwife-TBA partnership concept. 2. To explain's the step to develop partnership 3. To identify the existing midwife-TBA partnership 4. To identify problem-solvings 5. To discuss the follow-up The result of meetings are : 1. Increased understanding of midwife-TBA partnership 2. Increased knowledge of how o develop midwife-TBA partnersip 3. Draft of MOU 4. Inventory of existing form of midwife-TBA partnership, problem solutions This meeting is continued by regular meeting Community midwives-TBA partnership in Health centre level and village level.
3.2.8 two monthlyregular meeting between Community	This activity is a continuation of the activities of Regular Meeting between Community Midwives and TBAs in Health Centre Level The purpose of the meetings is to monitor the agreements which are stated on MoU. The MoU regulated such as : Task of midwives Task of TBA's, incentive for midwives and TBA (funded by jampersal) This activity is was carried out only in South Tangerang district, Banten Province.
3.3 Engaging private sector partners in MCH servi	
3.3.1 Workshops District/Cities CSOs Group	The purpose of these workshops is to evaluate the results of Public Private Partnership in districts/cities as an effort to increase immunization coverage through MCH programs The agenda of the workshops : a. Identification of obstacles/problems encountered during the implementation of partnership, and identify solutions in accordance to each of district/city's capability b. Evaluation of the implementation of partnership at district/city level c. Recording/filmyng of CSO's activities in each district/city d. The result of this workshop will be used to develop more activities for partnership with CSO In general, the results are : 1. Most of the activity to support development of partners has been done. 2. The CSO who following the partnership are : woman organizations, assosiations of profession, private manufacture, others private assosiation. 3. Most of related CSO have been conducted partnership activities.

3.3.2 Advocacy and facilitation to engage Private	This meeting was conducting in province and was attended by central, province and districts level, Basically this meeting is to advocation and socialization MCH and immunization programs to get support from private sector Objectives are : 1. To increase the understanding on MCH and immunization program 2. To increase the understanding on partnership concept 3. To increase the knowledge on how to develop partnership activities 4. To agree supporting partnership implementation Results of the meeting : 1. Increasing of understanding on MCH and immunization program 2. Increasing of understanding on partnership concept and how to develop partnership 3. Specific result : a. West java : they have signed with 18 CSO b. Banten : they have a meeting with several CSO c. South Sulawesi : Identification of CSO activities d. Papua : did not yet ready for doing the activity.
3.3.3 Evaluation for sector partners in MCH servic	The objective of the activity is to evaluate the progress of partnership activity in provincial and district level. The activity was planned to be conducted at central level, followed by PHO and DHO staff, but due to the partnership activity in West Papua was not implemented yet the activity was postponed to conduct in 2012

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Activity 4.1.Contracting out in Papua Province has not been implemented yet. Preliminary assessment has been completed towards developing project design. As full fund for this activity not yet received and contracting out of this activity required an one package contract, so its implementation delayed.<? xml:namespace prefix = o />

Activity 4.2. Incentive mechanism : The activity will conduct in 2013 as approved in GAVI HSS's reprogramming

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

The GAVI HSS operational research on incentive for cadre and salaried staff of health centre will be implemented in 2012. That is why the result is not yet as a consideration material to provide national health human resources incentives policy. Any how the result of operational research on incentive for cadres will be very important issue and material for country policy development

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2010 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2011 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2007	2008	2009	2010	2011		
3.Partnership formed with non-goverment											

Percentage of the target districts having joint re	N/A	N/A	100%	58%	N/A	N/A	N/A	38.37 %	58%		Up to 2011, total of district having joint regular meeting with CSO were 50 districts. The percentage of target achieved was 58%
4.Operational research on critical barri											
Pilot project on contracting health service provis	N/A	N/A	One district	-	N/A	N/A	N/A	0	0		As total fund required for this activity has not been received but contracting gout this activity needed an one package contract, so its implementation delayed. During 2011, preliminary assessment completed toward developing project design.
Operational research on incentives for caders and	N/A	N/A	Six districts	-	N/A	N/A	N/A	0	0		The activity will be conducted in 2013 as approved in GAVI HSS's reprogramming
1. Community mobilized to support MCH											
Percentage of community health workers (cadres) in	N/A	N/A	80%	24%	N/A	N/A	N/A	16.46 %	29.22 %	DHO	Up to 2011, total cadres have been trained : 61,397. The percentage of target achieved was 29,1%
Percentage of villages which received operational	44,78%	Survey (assessment GAVI-HSS) 2010	100%	-	N/A	N/A	N/A	-	-	DHO	Funds did not yet disbursed in 2011
2. Management capacity of MCH personel i											
Percentage of the target sub district with staff t	N/A	N/A	100%	24%	N/A	N/A	N/A	20.46 %	24%	DHO	Up to 2011, total of HC with staff trained were 411. The percentage of target achieved was 24%
Percentage of the sub-districts regulary following	N/A	N/A	80%	24%				20.46 %	24%	DHO	Up to 2011, total of HC following good management after training were 411. The percentage of target achieved was 24%

9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program

Major accomplishments as per four objectives to support the overall goal for maternal, infant and child health improvement, are provided below.

Objective 1(Community Mobilization to support MCH)

To achieved target on the objective 1, it has been implemented training of community cadres to achieved 80% Percentage of community health workers (cadres) in target sub districts (point A), and to achieved 100% Percentage of villages which received operational cost support, preceded by the implementation of the Services Availability Mapping and Village Mapping (point B) below.

A. Training of Community Cadres

By the end of 2011 atotal of 5.474cadres have been trained. Community cadre trainings have two mainbenefits, i.e. :

- community members to be better informed on health issues by capacity improvement,individually and collectively, to independently protect their own health

- The community have more confident to take up the MCH services and immunization from trained providers.

The training primarily covered Birth Preparedness and Complication Readiness use of MCH handbook and care and services available for pregnant and breastfeeding mother and new born, including immunization schedule. The cadres able to develop map on pregnant women and to mobilize them, in order to utilize delivery package including immunization by skilled birth attendant at health facilities.

The necessary training/IEC materials were developed and printed to be used to train cadres,Health Center staff, among others. In 2011, 20.000 books of Guideline of Child Health Care for Cadre have been printed and distributed. 9.000 books of Neonatal Essential Health Care Books have been printed and distributed.

The achievement of training community cadres up to 2011 has rised 61,397 or equal to 29,1 percent from thetarget.

B. Assessment and mapping of existing situation including health Services Availability Mapping:

As indicated in the2010 GAVI HSS 'APR , implementation of assessments was delayed, which caused obstacle to utilize baseline results for current phase of project implementations. In 2011, the data have been analyzed and the results have been disseminated a cross program at the central level, provincial and district level, as well as to the international partners. The results also publicized through the official website : www.gizikia.go.id.

The assessment findings includes map that used as:

1. Baseline planning for GAVI's second tranche

2. Advocate programs to the local government, political leaders, in order for them to allocate adequate resources to strengthen health service program notably immunization program.

3. Be used as a basis for health planning, especially on MCH and immunization services, and for monitoring of progress.

4. As a baseline for other health assessment activities

Further utilizationof findings for advocacy to local government, political leaders is still undergo. For detail clarification onassessment, describe on table 9.2.1.

<?xml:namespace prefix = o />

Objective 2 (Improved management capacity of MCH staff)

To achieved target on the objective 2, has been implemented Health Center with staff trained to achieved 100% percentageof the target sub district with staff trained in management, and to achieved80% percentage of the sub-districts regulary following good management practices after training.

The Decree of Minister of Health28/Menkes/SK/II/2004 states that Health Center is a center of health – oriented motivator of development, a center of community empowerment, covering individual and community health. As a consequence, Health Center needs to strengthen its management, including its human resource management, by doing trainings on MCH Management, so that the Health Center staff would be able to plan, implement, supervise, and report, as well as evaluate Health Center's performance.

Since 2010 the Indonesian government has been allocating operational funds for all Health Centers in Indonesia, called Biaya Operasional Kesehatan, or BOK (Operational Cost for Health Center from state budget). These funds are used to support a promotive and preventive health services. All Health Centers can use this BOK by first requesting the amount needed to their district/city Health Office, to cover all the promotive and preventive efforts in their area. This BOK request must go through a micro planning that not only to cover promotive and preventive actions but also to improve Health Center staff management knowledge.

One of GAVI programs is management training for Health Center staff, which is useful for Health Centers to utilize well the BOK fund according to the analysis and needs.

The above training improvement were primarily done by TOT trainings for PHO staff, to be then followed by the similar for DHO staff. The trained DHO staff would become trainer for Health Center staff,village midwife, as well as cadre.

It is expected that management of MCH and immunization activities will be strengthened in a more integrated mechanism.Besides managerial capacity, training on technical areas related to MCH and immunization will improve service provider's confidence which may in turn increase community satisfaction and increased service utilization. Midwives in the villages have a pivotal role both in community mobilization effort and as principal providers of out reach services.

The improved management capacity among the provider of MCH services has made services to the communities more affective and acceptable, leading to increased take up of services. Midwives in the villages have a pivotal role both in community mobilization effort and as principal providers of outreach services.

By the end of 2011,138 Health Center staff trained on Integrated management and Childhood Illness (IMCI) to avoid missed opportunity of Immunization, 321Health Center staff trained in Management of MCH and Immunization, and 1.920 midwives have been trained on Birth Preparedness and Complication, Readiness

The achievement of this objective up to 2011 has 411 Health Centre staff trained. That have achieved24% of the target. While the Health Centre that following good management aftertraining were 411 or 24 % the percentage of target achieved.

Objective 3 (Partnership formed with non-government agencies)

The Indicator achieved of Objective 3 in 2011 through the implementation of activities at 33district from 62 district in target end project. The activities includes :

a) Central level :

1. Identification of partners, development of action plans, formulation of MOUs,
2. Evaluation for Sector Partners in MCH Service Delivery to 5 Provincy (central level)
3. Coordination Meeting to Strengthen the Implementation at Central Level
4. Strengthening implementation of MOU joint monitoring meeting
5. Orientation & Sosialization MCH Policy to the IBI (Indonesian Midwife Organization) For 5Provincies,33 District / cities
6. Orientation on Providing Midwife - TBA partnership for 5 Provincies, 33 Districts/cities,
7. Advocacy and fasilitation for engaging Private Sector Partner in MCH service Delivery to 5Povince,

b) Provincelevel :

1. Workshop For District/Cities CSOs Group,
2. Evaluation for sector partners in MCH service delivery in Provincy Level

c) District level :

1. Technicall orientation on midwifes TBAs Partnership for Health Centers Team and Community Midwifes 33 Districts ,

2. Reguler Meeting CSOs group for Community mobilization and service delivery efforts,

d) HealthCenter level :

1. Reguler Meeting Community Midwives and TBAs in Health Centre Level,

2. Regular meeting every two months between Community Midwives and TBAs in Health center.

e) Villagelevel :

Reguler Meeting Community Midwives and TBAs in Village Level.

Health is basic human right and an investment as well as an obligation for all. Therefore, health issues cannot be handled by the health sector alone, but by all parties including private parties. If everybody cares about health problems, we will get the benefit on a better manpower quality and productivity. An improvement of MCH and immunization coverage cannot be all done by the health provider, as non government agencies such as private companies and CSOs must also participate for such improvement. A health sector partnership is a partnership that is developed to maintain and improve health. A partnership is cooperation between two parties or more, in a basis of equality, openness, and mutuality.

Progress of activity in partnership are as follows:

1. Initiating partnership with private companies such as :

a. West Java Province : PT Pupuk Kujang, PT KIIC and Toyota, PT Pertamina

b. South Sulawesi : PT. Semen Bosowa, PT. Citra Cable, PT. London Sumatera

2. Partnership with CSO such as midwife organization, IDI (Indonesian Practitioner Association), POGI (Indonesian Obstetrics and Gynecology Association). These organizations spread almost all over the country. Women Social Welfare (PKK), White Ribbon Alliance in Banten Province

3. Midwife – TBA partnership. In GAVI's 5 provinces, there are still many TBAs as the 2010 survey shows that there were 8,839. To completely eliminate TBA's roles is impossible because of cultural reason. One way to overcome this problem is to create a partnership between midwife and TBA in form of MoU. In many areas, this partnership has been going on.

In 2011, the progress of partnership was generally still on preparatory phase, by identifying and giving advocacy to various organizations that had been targeted for this type of cooperation. In order to attain an efficient, effective, and compliant co relation, it was necessary to create an MoU. The MoU's principles that have been developed between DHO and private organizations are: mutual understanding, mutual trust, the need to each other, close relation, assistance to each other, develop each other's potential, ability, strength, and mutual respect. In 2011, the progress achieved was the MoU drafting through dialogues between PHO, DHO, and the expected organizations for partnership. In 2012, these drafted MoUs are decided to be implemented.

Up to 2011, total of district having joint regular meeting with CSO were 50 districts. The percentage of target achieved was 58%.

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

The following problems were encountered during project implementation in 2011:<?xml:namespace prefix = o />

MANAGERIALPROBLEMS:

<!--[if !supportLists]-->1. <!--[endif]-->The total number of staff is not sufficient due a limited amount of GAVI

HSS management cost (6% from the total 1st tranche), which makes the staff of GAVI management are posted down to only provincial level of 3 people each, where as the project activities are also conducted at district/city and HC levels. These facts contributed to a low project realization

<!--[if !supportLists]-->2. <!--[endif]-->Difficulty of determining the costs in detailed plan budget due to varied standard of unit cost in each of district/city.

<!--[if !supportLists]-->3. <!--[endif]-->Activities that involve a big number of community and cadres are not easy to implement due to a limited number of Health Center staff and Health Office staff at district/city level, whilst the activities are conducted repeatedly with big classes.

<!--[if !supportLists]-->4. <!--[endif]-->The Indonesian financial regulation keeps changing, which makes the Project Implementation Manual must be adjusted accordingly, causing 3 months program implementation delay. In 2011, the Indonesian Government requested a project reprogramming,causing program implementation delay.

<!--[if !supportLists]-->5. <!--[endif]-->According to the regulation of Ministry of Finance, the direct grant must be acknowledged by the State Treasury Office (in GAVI's case Jakarta VI State Treasury Office).This means that all original documents of fund realization accountability by all project's districts/cities and HCs must be submitted to the central secretariat, which in many cases receives these documents late. This late accountability document submission to the central secretariat causes delay of distributing subsequent funds, which at the end caused low fund expenditures and activity implementations.

PROGRAMMATIC PROBLEMS:

<!--[if !supportLists]-->1. <!--[endif]-->Cadres Training: Limited number of DHO and Health Center staff who are capable of giving training to cadres particularly in Papua and West Papua Province caused a low target realization

<!--[if !supportLists]-->2. <!--[endif]-->Staff training: Limited number of DHO staff who are capable of giving training to Health Center staff, particularly in Papua province and West Papua province caused delay in conducting management – related training for Health Center staff

<!--[if !supportLists]-->3. <!--[endif]-->Partnership:A varied number of non government agencies for partnership need different advocacies. In 2011, Most of the partnership efforts were still at the evaluation phase regarding the importance of partnership phase, whereas in some project's districts/cities, they have reached the phase of MoU development in which the results were still not seen.

<!--[if !supportLists]-->4. <!--[endif]-->Operational Research: The funds disbursed by GAVI were in partial amount, whilst activities involving contracting out parties require a one package contract.

Alternative Solution

Managerial Problems :

<!--[if !supportLists]-->1. <!--[endif]-->Every level (central to districtlevel) assigned responsible person from programs to be directly participate in any GAVI HSS activities, as this act responsiveness have been stated in the "TechnicalTeam Decree" at central level assignment by Decree of MOH, and at provincial level assignment by the Decree of the Provincial Health Office.

<!--[if !supportLists]-->2. <!--[endif]-->The central secretariat made several revisions of detailed plan budget, according to the mechanism for revision from Ministry of Finance.

<!--[if !supportLists]-->3. <!--[endif]-->Health Center's staff were includedon cadres trainings

<!--[if !supportLists]-->4. <!--[endif]-->Project Implementation Manual was revised by adjusting to the existing regulation

<!--[if !supportLists]-->5. <!--[endif]-->A three monthly meeting was conducted between provincial level treasurer and central level treasurer

Programmatic Problems:

1. Trainers from central level helpgiving training

2. Some non government organizationshave taken part in partnership activities, and as for the partnership with IBI(Indonesian Midwife Association), PKK (Family Welfare Education), and ongoingmidwife – TBA partnership, they already have common cooperation with healthinstitutions to work with fund support from GAVI CSO.

Maternal and Child Health and Basic Immunization Assessmentshave been made by hiring consultant of Gajah Mada University in PegununganBintang district ofPapua province and in Raja Ampat district of West Papua province. Thisassessment will be used as a basis of General Selection Document for aprocurement process.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

<!--[if !supportLists]-->1. <!--[endif]-->Central level :<?xml:namespace prefix = o />

<!--[if !supportLists]-->– <!--[endif]-->The monitoring reports are submitted to the Bureau of Planning and Budgeting of Ministry of Health and to the BAPPENAS (National Development and Planning Board) together with the State Budget – funded report of activities. All these reports are submitted to the Jakarta VI State Treasury Office.

<!--[if !supportLists]-->– <!--[endif]-->GAVI implementing team works at each implementing unit and secretariat. The monitoring and evaluation (monitoring and evaluation) officers work at Secretariat of Directorate General i.e. Program and Information Division, who is appointed by the Director General Decree, thus avoiding a frequent replacement of staff.The team's works include the following:

<!--[if !supportLists]-->– <!--[endif]-->Monitoring and evaluation with external auditor (BPKP)

<!--[if !supportLists]-->– <!--[endif]-->Integrated monitoring at provincial/district/city level

<!--[if !supportLists]-->– <!--[endif]-->DG of Nutrition and MCH monitors/assists the process of fund accountability at the province and selected districts

<!--[if !supportLists]-->– <!--[endif]-->At least a monthly meeting between project management and GAVI Program manager

<!--[if !supportLists]-->– <!--[endif]-->Quarterly meeting between implementing units and the head of Bureau of Planning and Budgeting

<!--[if !supportLists]-->– <!--[endif]-->The Quarterly Report is submitted to the Bureau of Planning and Budgeting of Ministry of Health and to the BAPPENAS (National Development and Planning Board),together with the State Budget – funded report of activities.

<!--[if !supportLists]-->– <!--[endif]-->At least twice a year coordinative meeting among related units and provincial/district level

<!--[if !supportLists]-->– <!--[endif]-->At least 4 times a year the HSCC (Health Sector Coordinating Committee) conducts regular meeting

<!--[if !supportLists]-->2. <!--[endif]-->Provincial level :

<!--[if !supportLists]-->– <!--[endif]-->All financial accountability reports are submitted by all project's provincial level treasurer to the central secretariat, who then submit them to the Jakarta VI State Treasury Office as a basis for releasing SP2HL

<!--[if !supportLists]-->– <!--[endif]-->A team whose members are assigned by Director General of CDC Decree (to avoid afrequent replacement of staff) is responsible to monitor activities atprovincial/district/city level

<!--[if !supportLists]-->– <!--[endif]-->Monitoring and evaluation's mechanism at provincial level is done by creating a monitoring and evaluation team, of which each team is responsible for 4 district/cities

<!--[if !supportLists]-->– <!--[endif]-->Monitoring and evaluation covers up to thedistrict/city level

<!--[if !supportLists]-->– <!--[endif]-->The province takes part in almost all activities at districts/cities level

<!--[if !supportLists]-->– <!--[endif]-->The province consults to the central level

<!--[if !supportLists]-->– <!--[endif]-->At least twice a year coordinative meeting at provincial level and district level

<!--[if !supportLists]-->3. <!--[endif]-->Districts/Cities level :

<!--[if !supportLists]-->– <!--[endif]-->Monitoring and evaluation executive that works at district level is responsible for GAVI HSS activities at district/city level

<!--[if !supportLists]-->– <!--[endif]-->Districts/cities Monitoring evaluation team is set up by Decree of Head of Provincial Health Office

District Health Office (monitoring and evaluation team) conducts monitoring and evaluation of HSS activities at the selected Health Centers

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

<!--[if !supportLists]-->A. <!--[endif]-->Monitoring Implementation of Activities:<?xml:namespace prefix = o />

<!--[if !supportLists]-->1. <!--[endif]-->Central Level:

<!--[if !supportLists]-->- <!--[endif]-->Bureau of Planning and Budgeting, MOH monitors the implementation of GAVI HSS

<!--[if !supportLists]-->- <!--[endif]-->Through the Bureau of Planning and Budgeting, the report is submitted to National Planning and Development Board quarterly period,together with other activities funded by the State Budget

<!--[if !supportLists]-->- <!--[endif]-->National Planning and Development Board monitors the activities of the GAVI HSS

<!--[if !supportLists]-->- <!--[endif]-->Technical Team of GAVI routinely monitors the implementation of GAVI HSS

<!--[if !supportLists]-->- <!--[endif]-->Integrated NationalMonitoring and Evaluation System: GAVI HSS activities are reported together with the monitoring implementation of State Budget – funded activities

<!--[if !supportLists]-->2. <!--[endif]-->Provincial / District /City:
Provincial and district/city level integrate themselves on regular monitoring system.

Financial Monitoring:
GAVI HSS implementation units at central and provincial level (provincial/district/city health office) submit a monthly report to the secretariat of GAVI HSS, who will then recapitulates this report to and submit it to the program manager. This report goes to the State Treasury Office of Ministry of Finance every quarterly period for Direct Grant Approval Letter.
<!--[if !supportLineBreakNewLine]-->
<!--[endif]-->

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including Civil Society Organisations). This should include organization type, name and implementation function.

<!--[if !supportLists]-->1. <!--[endif]-->CSO<?xml:namespace prefix = o />

<!--[if !supportLists]-->a. <!--[endif]-->PKK (Family Welfare Educational class), an organization of mothers, has activities such as:

<!--[if !supportLists]-->- <!--[endif]-->DisseminatingMCH information during monthly wives gathering where DHO staff has opportunity to speak about MCH and immunization

<!--[if !supportLists]-->- <!--[endif]-->Activating “Dasa Wisma” (a group of 10 t0 20 neighborhoods) in South Sulawesi province

<!--[if !supportLists]-->b. <!--[endif]-->White Ribbon Alliance, a community organization of persons who concern about maternal health services. This organization spreads around Indonesia, and in Banten Province,it actively involves in socializing MCH booklets to housewives, including information about pregnancy routine checks

<!--[if !supportLists]-->c. <!--[endif]-->BPS,a private midwifery practice, is active in reporting MCH service and immunization data to the Health Centers.

<!--[if !supportLists]-->2. <!--[endif]-->Religious organizations

<!--[if !supportLists]-->a. <!--[endif]-->ALHIDAYAH and MUI are two Islamic organizations that spread across the country and are active in disseminating information about MCH booklets using as well as reproductive health among youth.

<!--[if !supportLists]-->b. <!--[endif]-->AISYAH and Fatayat NU, a wives organization where during their monthly Islamic oration they invite a speaker from the DHO to speak about MCH and immunization issues.

<!--[if !supportLists]-->c. <!--[endif]-->PERDAGI,Injili Christian Church, are two organizations in Papua province that take part in socializing the MCH booklets using and informing health and immunization schedules at Posyandu (integrated Health Post) at the end of the church service.

<!--[if !supportLists]-->3. <!--[endif]-->Private companies

PT. Pupuk Kujang and PT. FCC are two private companies that help giving supplementary food for babies at 10 posyandu in Karawang District.

Academic Institution : University of Indonesia, Gadjah Mada University, Hasanuddin University, Padjajaran University, Cendrawasih Univesity. They were assigned to analyze data of survey (VM and SAM). GajahMada University also under took assessment for contracting out in Papua.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

1.IBI (Midwife Organization) <?xml:namespace prefix = o />

Type of activities: GAVIHSS only pay to conduct some socialization of MCH and Immunization meetings to members of IBI, particularly socialization of new program, such as Jampersal (Health guarantyfor delivery in health facilities)

<!--[if !supportLists]-->2. <!--[endif]-->PKK (FamilyWelfare Educational Class)

Type of activities: GAVIHSS pay for socialization of MCH and immunization program to the members of PKK, then the members participated in some activities of cadres training on MCH and immunization services including MCH handbook.

<!--[if !supportLists]-->3. <!--[endif]-->Community figure/religious leader

Type of activities : GAVI HSS pay for training of religious/communityleaders in BPCP & using of MCHhandbook, then they implement in their religious/communityactivities

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective

- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

Planning was begun with the coordinative meeting with the implementing units at the Directorate General of Public Health (the present title: Directorate General ofNutrition, Maternal and Child Health) and the related units. The next step isto conduct meeting with the Provincial Health Office and District Health Officeto allocate the funds by using standard cost from the Ministry of Finance as well as local standard cost. Baselines used as reference are: number of cadres to be trained; number of Health Center staff to be trained, etc. by using secondary data from DHO.<?xml:namespace prefix = o />

<!--[if !supportLists]-->1.<!--[endif]-->Mechanism of channeling of GAVIHSS funds into the country:

GAVI Geneva transfers the money to the executing agency's account number i.e. Directorate General of Communicable Diseases and Environmental Health)

<!--[if !supportLists]-->2. <!--[endif]-->Transferring mechanism of GAVI HSS funds is as follows: 1. The Min. of Finance approved the budget of Secretariat Directorate General of Nutrition, Maternal and Child, formally known as State Budget Document. This means that all expenditures used by GAVI project follow the State Financial Mechanism and the State audit, 2.Directorate General of Disease Control and Environmental Health transferred the fund to Secretariat Directorate General of Nutrition and Maternal and Child Health's account number.

<!--[if !supportLists]-->3. <!--[endif]-->Channeling mechanism of GAVI HSS funds from central level to provincial and district level:

The funds are transferred to district level. Prior to the transferring, the head of PHO /DHO must sign the letter of integrity pact. Such mechanism was also applied by all implementing units at central level

Mechanism (and responsibility) of budget use and its approval:

The implementing units at central level and provincial/district level uses the GAVI HSS funds to conduct activities that are inline with the action plan/Detailed Plan Budget) approved by DG of CD & EH. The Program manager is responsible to ensure that the budget is used on the right track.

Mechanism of disbursement of the GAVI HSS funds :

First, the implementing units (central level and PHO/DHO) submit monthly Financial Report to the Program manager of GAVI HSS and to the DG of CD & EH. DG of CD and EH will then pass the report for getting legalization (SP3) at the Special Treasury Office-Jakarta VI with attached documents i.e. the recapitulation of the expenditure and the bank statement.

Auditing Procedures:

The auditing procedures refer to the Government of Indonesia regulation on audit mechanism. An internal audit isconducted by the Inspectorate General of Ministry of health, and anexternal audit isconducted by The Government's Internal Auditor Office (Badan Pengawasan Keuangan dan Pembangunan/BPKP).

Revision of Detailed Plan Budget:

In case of revision, the DHO proposes to the PHO, who will then propose it to the Program Manager of HSS. The Program Manager will pass it to the Director General of Communicable Disease and Environmental Health for approval.Revision is permitted for an adjustment of unit cost only. While the activities proposed must not change.

Constraints :

<!--[if !supportLists]-->- <!--[endif]-->Long Bureaucracy (fund planning, fund disbursement, budget claiming, accountability of budget use and its approval)

<!--[if !supportLists]-->- <!--[endif]-->Mechanism differences (and accountability) of budget use atcentral and

provincial/district level.

Action taken/Suggestion :

<!--[if !supportLists]-->- <!--[endif]-->New management team, including staff recruitment for new secretariat

<!--[if !supportLists]-->- <!--[endif]-->Budget allocation are made under the relevant DG (shifting fund disbursement authority from the DG of Communicable Disease & Environmental Health to the DG of Nutrition and MCH)

<!--[if !supportLists]-->- <!--[endif]-->Planning & monitoring meeting at various levels to solve problems

Change to management processes in the coming year

<!--[if !supportLists]-->- <!--[endif]-->GAVI fund has been allocated in the state budget. In this way, all expenditure used for GAVI project will apply to State Financial Mechanism and audited by the state.

<!--[if !supportLists]-->- <!--[endif]-->GAVI HSS is an integration of activities from various programs (MCH, immunization,health promotion program), therefore it has been decided that the technical coordinator of GAVI HSS is the Bureau of Planning and Budgeting

<!--[endif]-->

9.5. Planned HSS activities for 2012

Please use **Table 9.5** to provide information on progress on activities in 2012. If you are proposing changes to your activities and budget in 2012 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2012

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Original budget for 2012** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2012 actual expenditure** (as at April 2012)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2012** (if relevant)
Objective 1						
Assesment and mapping of existing situation relati	1. Utilization of survey data to accelerate the implementation plans of GAVI HSS 2. Coordinative meeting on VM and SAM data utilization 3. Integrated meeting on community responseabout immunization 4. Procurement of data processing equipments	224383				

Selection caders (CHWs) within their own communiti	1. Cadres training on MCH and immunization services including MCH handbook 2. Cadre capability improvement on neonatal health in the effort to increase immunization coverage	290163	37663			
Development procurement and distibution of IEC mat	1. Prints Books Children's Health Program 2. Prints IEC materials GAVI HSS 3. IEC media development with local content to the mountainous area of Papua and West Papua 4. Health worker training curriculum children	197231	4797			

Sensitization of community and religious leaders o	1. Socialization to religious leaders in BPCP & MCH handbook 2. Special emphasis on the low coverage of MCH and UCI in village level (Acceleration of immunization in the low coverage area) 2.1. Coordination Meeting in Health Center (Local government, Religious/Community Leaders, etc) 3. Advocacy To TOMA / TOGA against denial of immunization in the province of Banten 4. Advocacy To TOMA / TOGA against denial of immunization in the province of West Java 5. Advocacy of MCH programs and immunization to religious organizations in 5 provinces 6. Socialization increase immunization coverage vitamin k1 Hb0 Jayapura City 7. Assisting in the implementation of the Training Cadres	124039	16000			
Objective 2						
	1. Strengthening reporting and recording with integrated individual registration system 1.1. Review Existing tools 1.2. Review indicators and target data 1.3. Cross Program meeting in MoH (DG of Nutrition and MCH, DG of DC & EH, DG					

Needs assesment Moh/PHO/DHO staff of MCH managemen	of Health Care and Center of Health Information System) 2. Improving data quality through DQS (Data Quality Self Awareness) 2.1. Outcome Study of DQS (coverage survey) 3. Special emphasis on the low UCI and MCH coverage in villages (acceleration of immunization implementation) 3.1. Coordinative and evaluative meeting (cross sector/cross program at Provincial level) 4. Meeting of GAVI planning for 2nd tranche (2012-2014) 5. Coordinative meeting to implement GAVI HSS's 2nd tranche 6. Mother classroom training to improve immunization coverage of MCH and district midwives tk 7. Coordination and evaluation at provincial level for districts / cities with Traffic Related Sectors 8.Facilitation Komda KIPI advocacy program on immunization KIA	416566	9245			
	1. Strengthening reporting and recording with integrated individual registration system 1.1. Socialization, Advocacy of the utilization and usefulness of					

	the tools to the local government Strengthening of reporting and recording system with individual computerized data (immunization and MCH) 2. Special emphasis on the low UCI and MCH coverage villages (acceleration of immunization implementation) 2.1. Advocacy to local government (Province and District) 2.2. Coordination and evaluation meeting (cross sector/cross program in Provincial level) 2.3. Coordination meeting to develop MCH-Immunization Strategy 3. Review of Indicators and Data Targets (rr refinement using a computerized individual data) Review of Indicators and Data Targets (rr refinement using a computerized individual data) 4. Cross-program coordination meetings with the relevant Ministry of Environment Health (Sub Infant, Mother, PI, P2PL and Media Centre) coordination meetings with Traffic Programme of the Ministry of health related (Sub Infant, Mother, PI, P2PL and Media Centre) 5. Advocacy at the Local Government Tk. Local Government Advocacy						

Advocacy by Moh/PHO staff to district administrati	Center at Tk. center 6. Advocacy meeting with Cross Sector / Traffic Program MCH programs related to strengthening and improving immunization coverage Advocacy meeting with Cross Sector / Traffic Program MCH programs related to strengthening and improving immunization coverage 7. Advocacy Immunization staff at the Provincial Government support funding for the MCH and Immunization Tk. Advocacy Provincial Immunization staff at the Provincial Government support funding for the MCH and Immunization Tk. Province 8. Meeting Coordination and Evaluation Program Cross, Cross-Sector business meeting GAVI Provincial Traffic Coordination and Evaluation Program, Cross-Sector business Provincial GAVI 9. Advocacy meeting at the Provincial Traffic Related Sectors of the District / Municipal Strengthening Program for MCH and Immunization (in Prop. JABAR) Advocacy meeting at the Provincial Traffic Related Sectors of the District / Municipal Strengthening Program for	141042	19936			

	MCH and Immunization (in Prop. JABAR) 10. Advocacy meeting at the Provincial Related Sectors of the District / Municipal Strengthening Program for MCH and Immunization (in Prop. SUL-SEL) Advocacy meeting with Provincial Traffic Related Sectors of the District / Municipal Strengthening Program for MCH and Immunization (in Prop. SUL-SEL) 11. Mentoring LP / LS Advocacy & KIA Immunization Assistance to Regional LP / LS Advocacy for Immunization and MCH Regional					

Development and distribution of management guideli	1. Strengthening reporting and recording with integrated individual registration system 1.1. Procurement of laptop and modem 2. Special emphasis on the low UCI and MCH coverage villages (acceleration of immunization implementation) 2.1. Coordination and evaluation meeting (cross sector/cross program in Provincial level) 3. Printing the guidelines 4. Review Guidelines for Integrated Management of MCH and Immunization Health Center 5. Procurement Monitoring & Supervision Tools Bimtek	62036				
	1. Strengthening reporting and recording with integrated individual registration system 1.1. TOT at central level 1.2. Cascade training di Province dan and District 2. Improving data quality through DQS (Data Quality Self Awareness) 2.1. Capacity building for operators in District and Health Centre level 2.2. Implementation of DQS in Health Center 3. Special emphasis on the low UCI and MCH coverage villages (acceleration of					

Plan, design and conduct training of district trai	immunization implementation) 3.1. Integrated micro planning training Province level 4. Orientation oh of IMCI structure in South Sulawesi 5. Plan and redesign Material for IMCI Training 6. Trial of leaflet, poster specifically in Papua and West Papua 7. TOT Management clinic in an effort to increase MCH and Immunization Coverage 8. Mentoring IMPLEMENTATION IN HEALTH MANAGEMENT (By Responsible Program) 9. Preparation Planning Directorate IMCI training. Child Health Development 10. The trial Leaflets, Posters with Local Content Areas in Papua	314928	12382			
	1. Training on integrated management of childhood illness including young invant to avoid missed opportunity of immunization at birth 2. Training of MCH management fo health centre 3. Strengthening of reporting and recording with integrated individual registration system 3.1. Piloting tools in selected Provinces 3.2. Training for Puskesmas staffs 3.3. Mentoring					

Puskesmas team training in microplaning, supervisi	RR using integrated individual Data 4. Special emphasis on the low UCI and MCH coverage villages (acceleration of immunization implementation) 4.1. Mentoring implementation of imunization in selected villages 5. Special emphasis on the low UCI and MCH coverage villages (acceleration of immunization implementation) 5.1. Integrated microplanning training at District level 6. PWS meeting 7. Management Training Health Center 8. TOT Preparation Meeting Management Health Center in an effort to increase MCH and Immunization Coverage 9. Training midwives in the delivery capacity of BCG immunization in infants at health center level 10. Review IMCI for health centers Officer 11. Disiminasi MTBS-M for GAVI area 12. IMCI implementation-Training M dikabupaten GAVI 13. Disiminasi Implementation of IMCI-M for 5 GAVI Province 14. Training for Volunteers MTBS-M Phase 1 (Province of South Sulawesi, West Java	1792915				

	and Banten) 15. Increased partnerships with professional organizations, NGOs, community-based organizations in increasing immunization coverage and quality of life of infants					

Strengthening Implementation of MCH-Immunization	1. Assessment of MCH and Immunization material for the Midwive Institution 1.1. Coordination meeting to discuss "The Attemps to Strengthen implementation of MCH and Immunization material" for Midwive Institution 1.2. Assessment of MCH and Immunization material for the Midwive Institution 2. Development guideline to "Strengthen the implementation of MCH and Immunization material" 2.1. Meeting MoH and selected Institution 2.2. Operational trial of the guideline 2.3. Revision of guideline based on input from the operational trial 2.4. Printing and distribution guideline 2.5. Socialization Guideline to 51 institution 3. Assistance and mentoring on implementation of guideline Implementation of MCH Immunization material" 3.1. Technical Assistance and mentoring the implementation of guideline "Strengthen Implementation of MCH and Immunization material" 3.2. Monitoring and Evaluation the utilization of guideline	345768				
Objective 3						

Identifications of partners, development of action	1. Technicall orientation on midwifes TBAs Partnership for Health Centers Team and Community Midwifest 33 Districts and Cities 2. Evaluation for Sector Partners in MCH Service Delivery to 5 Provincy (central level)	44608				
Strengthening coordination,	1. Strengthening coordination, implementation of MOU, including regular consultations and joint monitoring and evaluation 2. Technical Orientation on MCH Regulation Janpersal Vaccination, MCH handbook for Health Center and team midwives 3. Reguler Meeting CSOs group for Community mobilization and service delivery efforts 4. Reguler Meeting Community Midwives and TBAs in Health Centre Level 5. Reguler Meeting Community Midwives and TBAs in Village Level 6. Regular Meeting with Community Leaders in Village Level Efforts Village Community mobilization 7. Strengthening Partnership Meeting Midwives and Shamans in Improving Immunization Coverage 8. Activation Forum KIA communication between stakeholders					

implementation, of MoU	in the field of immunization 9. Strengthening Implementation Coordination Meeting MOU with CSO 10. Regular Meeting of Midwives and Maternity Shaman at health center level 11. Review of Implementation of the MOU with the PPP / CSR in order to Improve MCH and Immunization Coverage 12. Technical Orientation Regulations Janpersal Vaccination on MCH, MCH handbook for Health Center and team of midwives 14. Technical Orientation on Midwifes - TBA's Partnerships for Health Centers and Community Midwifes Team 15. Orientation on Providing Midwifes - TBA Partnership for Provincies 5, 33 Districts / cities 16. Regular Meeting CSOs group for Community mobilization and service delivery efforts 17. Regular Meeting Community Midwives and TBAs in Village Level	211320				
	1. Engaging private sector partners in MCH service delivery, including orientation to government policies on MCH, and sensitization of TBAs and private midwives 2. Evaluation for sector partners in MCH service delivery in					

Engaging private sector partner in MCH service del	Provincy Level 3. Advocacy and Campaign Delivery at a health facility preparedness complications in childbirth and postpartum Tk Provincial Advocacy and Campaign Delivery at a health facility preparedness complications in childbirth and postpartum Tk Province 4. Advocacy MCH and Immunization Program with the CSO and universities in 10 District / Municipal Advocacy MCH and Immunization Program with the CSO and universities in 10 districts / cities 5.Workshop For District / Cities CSO, s Group Workshop For District / Cities CSO, s Group 6. Coordination Meeting / Regular Meeting with TOMA, TBA, Cadres Cross-Sector District Level Coordination Meeting / Regular Meeting with TOMA, Duku Kader Cross-Sector in district Level 7. Regular meetings with the CSO for Public Mobilization and Services	245914				
Objective 4						
Pilot Project in contracting health services provi		44292				
Operational research on incentives for caders and		44292				
Support Cost						
Management Cost		218447	51062			

Monitoring & Evaluation	1. Special emphasis on the low coverage of MCH and UCI in village level (Acceleration of immunization in the low coverage area)) 1.1. Assistance and mentoring 2. Strengthening of reporting and recording system with computerized individual data (immunization and MCH) 2.1. Evaluation progress and utilization of the system 3. Improving data quality through DQS (Data Quality Self Assessment) 3.1. Stepwise Monitoring from central to province/district for implementation of DQS	334765	59055			
Technical Support		50420				
		5103129	210140			0

9.6. Planned HSS activities for 2013

Please use **Table 9.6** to outline planned activities for 2013. If you are proposing changes to your activities and budget (reprogramming) please explain these changes in the table below and provide explanations for each change so that the IRC can approve the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
Objective 1	Community mobilized to support MCH				
Development procurement and distibution of IEC mat		594455			

Sensitization of community and religious leaders o	1. Socialization to religious leaders in BPCP & MCH handbook 2. Special emphasis on the low coverage of MCH and UCI in village level (Acceleration of immunization in the low coverage area)) 2.1 Coordination Meeting in Health Center (Local government, Religious/Community Leaders, etcl)	57891			
Provision of small grants for the operational cost		1191364			
Objective 2:	Management capacity of MCH personnel improved				

Needs assesment Moh/PHO/DHO staff of MCH managemen	1. Strengthening of reporting and recording with integrated individual registration system 1.1. Review Existing tools, 1.2. Review indicators and target data 1.3. Cross Program meeting in MoH (DG of Nutrition and MCH, DG of DC & EH, DG of Health Care and Center of Health Information System) 2. Improving data quality through DQS (Data Quality Self Awareness) 2.1. Outcome Study of DQS (coverage survey) 3. Special emphasis on the low UCI and MCH coverage villages (acceleration of immunization implementation) 3.1. Coordination and evaluation meeting (cross sector/cross program in Provincial level)	260656			

Development and distribution of management guideli	1. Strengthening of reporting and recording with integrated individual registration system 1.1. Procurement of laptop and modem 1.2. Development of tools 1.3. Piloting the tools in selected province and finalizing the tools 1.4. Printing guidelines for RR individual data 2. Special emphasis on the low UCI and MCH coverage villages (acceleration of immunization implementation) 2.1. Review MCH-Immunization integrated guideline of immunization and MCH 3. Printing the guidelines	60649			
Objective 3:	Partnership formedwith non-government agencies				
Strengthening coordination, implementation, of MoU	1. Strengthening coordination, implementation of MOU, including regular consultations and joint monitoring and evaluation	75347			
Engaging private sector partner in MCH service del	1. Engaging private sector partners in MCH service delivery, including orientation to government policies on MCH, and sensitization of TBAs and private midwives	119702			
Objective 4:	Operational research on critical barriers performed				

Pilot Project in contracting health services provi		1103825			
Support Cost					
Management Cost		118958			
Monitoring & Evaluation	1. Special emphasis on the low coverage of MCH and UCI in village level (Acceleration of immunization in the low coverage area)) 1.1. Assistance and mentoring 2. Strengthening of reporting and recording system with computerized individual data (immunization and MCH) 2.1. Evaluation progress and utilization of the system 3. Improving data quality through DQS (Data Quality Self Assessment) 3.1. Stepwise Monitoring from central to province/district for implementation of DQS	127479			
Technicall Support		11765			
		3722091			

9.6.1. If you are reprogramming, please justify why you are doing so.

9.6.2. If you are reprogramming, please outline the decision making process for any proposed changes

9.6.3. Did you propose changes to your planned activities and/or budget for 2013 in **Table 9.6** ? **No**

9.7. Revised indicators in case of reprogramming

If the proposed changes to your activities and budget for 2013 affect the indicators used to measure progress, please use **Table 9.7** to propose revised indicators for the remainder of your HSS grant for IRC approval.

Table 9.7: Revised indicators for HSS grant in case of reprogramming

Name of Objective or Indicator (Insert as many rows as necessary)	Numerator	Denominator	Data Source	Baseline value and date	Baseline Source	Agreed target till end of support in original HSS application	2013 Target

9.7.1. Please provide justification for proposed changes in the **definition, denominator and data source of the indicators** proposed in Table 9.6

9.7.2. Please explain how the changes in indicators outlined in Table 9.7 will allow you to achieve your targets

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
HSS AusAID	49415000	2011-2016	Improvement of Health Workforce, Health Financing and Health Policy
HSS GFATM Round-10	36142479	2011-2016	Strengthening National Health Information System and Pharmaceutical and Health Product Management

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any

MOH, DHO, PHO	The achievement of Indicators: - All implementing units at central level developed tools for monitoring - All responsible person from implementing units trained those at provincial and district level on how to fullfil the tools. - Tools were fullfilled by responsible person for GAVI HSS at district level,to be then recapiulated by DHO and validated by PHO - The recapitulation of DHO's report was validated by central level. - DHO and PHO were invited by the central level to verify their reports - Reports from DHO, PHO to central level should be signed by the Head of DHO/PHO Financial Report : - District Health Office sent the Financial Report to PHO. - The recapitulation of the reportwas sent by PHO to central level (Program Manager of HSS) including its original receipt - Program Manager then sent the report to DG of CD & EH. - The recapitulation of the reportwas sent by DG of CD & EH to Ministry of Finance (to the Special Treasury Office-Jakarta VI) for requesting the legalization of the expenditure. - Prior to the above step, the secretariat at provincial and central level verified all the original receipts of the budget used and to see if the budget and activities had been used on the right track	- Facility based, Reports from some regions are not timely, - Under reported and/or over reported

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

APR Form is already comprehensive. The difficulty is more on data and information collecting from the regions,considering GAVI HSS area coverage that ranges from village level to provincial level.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? 5

Please attach:

1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report **(Document Number: 8)**
2. The latest Health Sector Review report **(Document Number: 23)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. TYPE A: Support to strengthen coordination and representation of CSOs

This section is to be completed by countries that have received GAVI TYPE A CSO support 1

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

ACE	:	Association of Community Empowerment
CARE	:	Catholic Relief Everywhere
IBI	:	Indonesian MidwivesAssociation
IDAI	:	Indonesian PeadeatricianAssociation
IMC	:	International Medical Corps
Kuis	:	Coalition for Health Indonesia
Gerakan Pramuka.	:	Indonesian Scout Movement
MoH	:	Ministry of Health
PP Aisyiyah	:	Central Board of Aisyiyah
PP Muslimat NU	:	CentralBoard of Muslimat Nahdlatul Ulama
YKAI	:	Indonesian Child Welfare Foundation
PATH	:	Program forAppropriate Technology in Health
Perdhaki	:	Association of Voluntary Health Services in Indonesia
Pelkesi	:	Association of Christian HealthService in Indonesia
PKBI	:	Indonesian Family Planning Association
TP-PKK	:	Family Welfare Movement

10.1.1. **Mapping exercise**

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation.

Please describe the mapping exercises, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed **(Document number)**

If the funds in its totality or partially utilized please explain the rational and how it relates to objectives stated in the original approved proposal.

This information has been reported in APR 2010,thus will not be described in this APR.

If there is still remaining balance of CSO type A funds in country, please describe how the funds will be utilised and contribute to immunisation objectives and outcomes as indicated in the original proposal.

In 2011, there is still remaining balance of CSO type A fund. It has been utilized for CSOcoordination meeting. The number of remaining balance can be checked in table 10.1.3

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

This information has been reported in APR 2009,thus will not be described in this APR.

10.1.2. **Nomination process**

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

This information has been reported in APR 2010,thus will not be described in this APR.

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

This information has been reported in APR 2010,thus will not be described in this APR.

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

This information has been reported in APR 2010,thus will not be described in this APR.

Please provide the list of CSOs, name of the representatives to HSCC or ICC and their contact information

Full name	Position	Telephone	Email
Azizah Aziz	Consortium (Muslimat NU)	+6221 7805763 / +628118705068	azizah_pri@yahoo.com
Joedyaningsih SW	Secretary General Indonesian Scout Movement	+6221 3507645 / +6281380578888	kwarnas@centrin.net.id / joedyaningsih_sw@yahoo.co.id
Susi Soebekti	Head of working group 4 TP. PKK	+6221 7981254 / +6281314888828	secretariat@tp-pkkpusat.org / jan_andrianto@yahoo.co.id
Tuminah Wiratnoko	Treasure of Indonesian Midwives Association	+6221 4247789 / +62811781131	ppibi@cbn.net.id / tumwiratnoko@yahoo.com

10.1.3. **Receipt and expenditure of CSO Type A funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	0	0
Remaining funds (carry over) from 2010 *(B)*	3,675	33,405,975
Total funds available in 2011 *(C=A+B)*	3,675	33,405,975
Total Expenditures in 2011 *(D)*	3,673	33,390,000
Balance carried over to 2012 *(E=C-D)*	2	15,975

Is GAVI's CSO Type A support reported on the national health sector budget? **Yes**

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

This section is to be completed by countries that have received GAVI TYPE B CSO support1

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

ACE : Association of Community Empowerment

CARE : Catholic Relief Everywhere

IBI : Indonesian MidwivesAssociation

IDAI : Indonesian PeadeatricianAssociation

IMC : International Medical Corps

Kuis : Coalition for Health Indonesia

Gerakan Pramuka. : Indonesian Scout Movement

MoH : Ministry of Health

PP Aisyiyah : Central Board of Aisyiyah

PP Muslimat NU : CentralBoard of Muslimat Nahdlatul Ulama

YKAI : Indonesian Child Welfare Foundation

PATH : Program forAppropriate Technology in Health

Perdhaki : Association of Voluntary Health Services in Indonesia

Pelkesi : Association of Christian HealthService in Indonesia

PKBI : Indonesian Family Planning Association

TP-PKK : Family Welfare Movement

Cons : Consortium

CHP : Centre for Health Promotion

Note :

For table 10.2.5 : Because of some columns cannot be filled in accordance to the real report or condition, we have attached the file titled " APR CSO 2011 Final" in the attachment section ("other" column) for detail information.

10.2.1. **Programme implementation**

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

<u>Progress of Implementation:</u>

Pramuka and PKK had completed the activities of GAVI phase 1 in December 2010, and no activities in 2011 because of the delay in the transfer of the phase II fund. Along 2011 only 2 CSOs, Consortium and IBI conducted activities of GAVI phase 1.

Here is the elaboration of the progress of the CSOs' activities:

1. Consortium (Jan – Oct 2011)
2. Conducted workshop to disseminate the initial data collection report which is the result of base line

survey in Oct-Nov 2010. The initial data is used by Consortium to develop a work plan for implementing activities in 2 provinces. Also through this workshop Consortium socialized program GAVI in their project areas in West Java and South Sulawesi.

3. Conducted preparation of Integrated Training Modules on routine immunization and MCH. Consortium developed 5 types of modules, namely: module for ULM, MLM, PLM, PSS, and TOM. In total all these modules were printed 2500 books and distributed for training participants. The preparation involved Centre for Health Promotion, Directorate of Immunization, Agency for Health Human Resource Development and Empowerment, as well as Directorate of MCH.
4. Conducted trainings in 2 provinces. There are 5 types of trainings: Training Leader/ manager Provincial Level Up (ULM), Training Leader / Manager District Secondary Level (MLM), Training of health centre personnel / training of peripheral level (PLM), Executive Level Staff Training private sector (PSS), Cadre Training Village Level, Training of Motivator (TOM)
5. Media Dissemination / Public Campaign. The development of media and public campaign involved Centre for Health Promotion, Directorate of Immunization, and Directorate of MCH. Before the media and public campaign were produced, they were tested in 2 districts in each of 2 provinces. (in South Sulawesi Province: Sidrap and Jeneponto; in West Java Province: Kuningan and Ciamis
6. Supportive Supervision Implementation

Supervision was conducted in 7 Districts: in West Java Province: Kuningan, Sukabumi, Purwakarta and Ciamis; in South Sulawesi Province: Sidrap and Jeneponto). The supervision in those 7 districts revealed that there had been community elucidations in social religious gathering ("Pengajian" and "arisan"), and home visits to pregnant mothers, lactation mothers as well as mothers with under 5 ages kids. There had also been information dissemination through local mass media and television, in addition to the campaign media produced by consortium centre.

1. **IBI (Jan – Oct 2011)**

1. Conducted workshop to disseminate the initial data collection report which is the result of base line survey in Oct-Nov 2010. The initial data is used by IBI to develop a work plan for implementing activities in 2 provinces. Also through this workshop, IBI socialized program GAVI in their project areas in West Java and South Sulawesi.

2. Conducted trainings for Midwife/Nurse

The training activities for midwife/nurse were started with the development of modules involving Centre for Health Promotion, Directorate of Immunization, and Directorate of MCH. The training conducted in 3 levels: training in the centre, province and district levels. In the next step, training participants from District levels would train cadres/traditional nurse ("dukun"). In the year 2011, the trainings for cadres/"dukun" were conducted in 50 villages in Bogor District, out of 100 target villages. Remaining targets will be done in 2012-2013.

3. Dissemination of IEC Media

The media was developed involving Centre for Health Promotion, Directorate of Immunization, and Directorate of MCH. The media developed are leaflet, poster, flipchart, bag, t-shirt, and pin.

4. Community Outreach

Village midwives who have been trained, conducted group elucidation in Integrated Health Post (Posyandu). In addition, cadres/"dukun" conducted home visits making use of IEC kit.

1. **Implementing Agency (Center for Health Promotion, MoH):**
2. Conducted CSO Coordination Meeting

The coordination meetings were aimed to discuss activity preparations and program progress of CSOs. Besides CSOs, the meetings involved key stakeholders in the immunization and MCH programs from MoH. The coordinating meetings were held twice in June 2011

1. Developed and produced GAVI Newsletter

There had been 2 edition published in 2011, which covered activities of all 3 components of GAVI Phase II activities in Indonesia.

1. Conducted Monitoring and Evaluation (Monev)

The monitoring and evaluation were conducted only in one province, South Sulawesi. The activity was aimed to monitor and evaluate if CSOs (IBI and Consortium) in provincial and district level conducted coordination with the Health Office in provincial and district level. Its aim was also to identify problems encountered during implementation of the program, and provide recommendation.

Monitoring and evaluation in South Sulawesi revealed no significant problem found and that all CSOs (IBI and Consortium) in provincial and district level had coordinated well with the Health Office in provincial and district level. And the program of CSOs goes according to the work plan.

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

Lead Implementing Organization

The lead in implementing the activities is still the Centre for Health Promotion within the MoH. While the GAVI Alliance CSO Support is implemented by PKK,Pramuka, Consortium and IBI. PP Muslimat NU is the lead organization of Consortium.

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

The GAVI support has enabled MoH and the CSOs involved to strengthen their collaboration in immunization and MCH services. MoH isnot only channeling financial support, but also technical support for all CSOsinvolved. Each CSO invited other CSOs and program holders (Directorate General ofNutrition, Immunization, Mother, Child Health) on each of their activities coordinatingmeetings where they can share data and provide inputs. For instance, IBI andConsortium's baseline data were welcomed by MoH to compliment their data forfuture intervention and programs. While MoH shared their updated data on immunization and MCH service.

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

The GAVI project has led to the increase of CSOinvolvement in Immunization and health system strengthening. In 2011, participants that had been trained by 2 CSOs : IBI and Consortiumempowered and mobilized the community in immunization and MCH. For example in IBI : cadres that had been trained reached families in village to give counseling and information about immunization and MCH. and in Consortium, home visit/counseling about immunization and MCH had been done by cadres/motivator in village level to pregnant women as well as to household with babies and children.

GAVI CSOs also involved other CSOs to support their program. For example : IBI involves PPNI/Persatuan Perawat Nasional Indonesia for the implementation programs and Consortium involves PPKMI/Perkumpulan Pendidik dan Promotor Kesmas Indonesia for baseline survey data processing and analysis.

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

The delayed disbursement of funds resulted in the postponement of implementationsand CSOs' abilities to meet the milestones stated on the proposal and Plan ofAction.

Trainers of PKK and Pramuka which had been trained in 2009 could only train their cadresand scouts in 2012. The delay probably will influence the quality of trainings conducted.

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

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

Table 10.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2011	Outcomes achieved
Gerakan Pramuka (Participatory Orientation; National Operation)	MCCI Project as stated on APR 2010	Scout Training	200 scout leaders train ; 400 roufer scout train ; 8000 group at district education for target
Consortium (PP Muslimat NU, PP Aisiyah, Perdhaki) – Religious Based Organization; Empowerment Orientation; National Operation	MCCI Project as stated on APR 2010	•Working Group Meeting •Beginning and End of Data Collection routine immunization and MCH as well as surveys of KAP (Knowledge, Attitude, Practice) •Socialization and Workshop at the Center & Regions •Preparation of Integrated Training Modules on routine immunization and MCH •Supervise preparation of the instrument of program activities (supportive supervision Check) •Doubling test IEC Books/Guides and Routine Immunization routine MCH •Training Leader/ manager Provincial Level Up (ULM) •Training Leader / Manager District Secondary Level (MLM) •Training of health centre personnel / training of peripheral level (PLM) •Executive Level Staff Training private sector (PSS) •Supportive Supervision Implementation •Monitoring Evaluation •Cadre Training Village Level; Training of Motivator (TOM) •Media Dissemination / Public Campaign	3 coordination meeting at central level, 2 coordination meeting at Province level, 2 coordination meetings at district level beginning of data collection is accomplished •Socialization and Workshop at the Center & Regions Conducted •Establishment of integrated training modules on routine immunization and MCH produced and distributed •Ceklist preparation of supportive supervision accomplished •Produced and distributed 2,000 Regular Routine Immunisation Handbook and the Maternal and Child Health •35 people trained and skilled about routine immunization, maternal child health, integrated training and logistics management. •70 people trained and skilled about routine immunization, maternal child health, integrated training and logistics management. •267 people trained and skilled about routine immunization, maternal child health, integrated training and logistics management in 4 distric (Jeneponto, Sidrap, Ciamis, dan Kuningan) •450 people trained and skilled about routine immunization, maternal child health, integrated training and logistics management. •Supportive Supervision Conducted •Monitoring Evaluation Conducted 212 people trained and skilled about routine immunization, maternal child health Media campaign produced and distributed -2000 Leaflet (100 %) -1000 T-Shirt (10 %) - 1.600 Banners and spanduk (80 %) - 2000 Pins (100 %)

IBI (Professional Organization; Empowerment Orientation; National Operation)	MCCI Project as stated on APR 2010	•Trainings -ToT for midwives and nurses from provincial and regency level. -midwives and nurses in regency level are trained -Cadre and accoucheuse training in sub district level. •Dissemination of IEC - Development, production and dissemination of IEC materials - Radio talkshow on one regency of each province •Community Outreach -Posyandu coaching meeting by midwives and cadre. - Monthly meeting and technical couching in Posyandu. - Community elucidation by midwives/nurses -Home visit elucidation by cadre - Socialization activities through meeting, program launching and campaign. -Agreement reached about the program comprehension and action planning implementation program.	18 trainers from central and provincial level, 25 trainers from regency level. 511 midwives and nurses in regency trained. 250 Cadres in sub district level (in Bogor) trained Pocket book 5000 pcs, Leaflet 2000 pcs, Poster 2000 pcs, Pin 500 pcs, T-shirt 500 pcs, Flipchart 500 pcs.50 Community elucidation in Bogor, 2500 Home visit Socialization and Advocacy in 20 sub districts and 100 village level Plan of Action for cadre training in 50 villages and community education, home visit by cadres.
TP PKK (Women Empowerment Orientation; National Operation)	MCCI Project as stated on APR 2010	- Increasing health promotion - Monitoring and Evaluation	3,600 cadres trained conducted health promotion. Monitoring and Evaluation has been conducted in 2010

Please list the CSOs that have not yet been funded, but are due to receive support in 2011/2012, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

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

Table 10.2.1b: Planned activities and expected outcomes for 2011/2012

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2011/2012	Expected outcomes

IBI (Professional Organization; Empowerment Orientation; National Operation)	Community organization has one of main objective improve knowledge for midwives	Training of health officers to increase routine immunization and MCH coverage •Development and production of curricula / training materials / modules for nurse, midwives, cadres/TBAs and IEC on immunization and MCH. •Development and production of handbook on immunization and MCH for nurse, midwives, cadres and TBAs. •Training of Trainers for Nurse and Midwives in Central level. •Training of Trainers for Nurse and Midwives in South Sulawesi Province. •Training for Nurses/Midwives from Puskesmas in 3 districts in South Sulawesi. •Training of Trainers in West Java Provincial level. •Training for Nurse/Midwives of Puskesmas from 2 Districts in West Java Public Empowerment in Immunization and MCH in 5 District in West Java province and South Sulawesi province •Training for cadres/TBA from Puskesmas/Sub District in 5 District •Public health promotion Monitoring and evaluation Development of Project Report	All Trainings are aimed to increase the trainees' knowledge and skills in mobilizing public and conduct health promotion to increase immunization and MCH coverage. 2,000 sets of curricula/training materials / modules are available for Training of Trainers, training for health nurse/midwives. 5,000 pocket book for nurse / midwives and 5,000 pocket book for cadres / TBAs on increasing routine immunization and MCH coverage. 26 people from South Sulawesi and West Java. Timeline: April 2011 32 people from provincial and district level (3 districts @ 5 persons). Timeline: Mei 2011 3 districts (2 bataches in paralel) @ 64 persons from 11 sub districts. Timeline: May 2011 29 people including 10 people from district level (2 districts @5 persons). Timeline: May 2011 2 districts (2 batches in paralel) @ 109 persons. Timing: May 2011 This activity is aimed to enable cadres/TBAs to have the ability to empower and mobilize the community in immunization and MCH. Midwives from 50 villages in sub district (@ 5 persons) 1825 cadres reached The monitoring and evaluation activities are aimed to measure if the public gained information on immunization and MCH. Outcome Provision of data on the development of project areas in terms of immunization and MCH coverage. Identification of solutions if the problems faced during the program commencement.

Consortium (PP Muslimat NU, PP Aisiyah, PERDHAKI) – Religious Based Organization; Empowerment Orientation; National Operation)	Community organization with religion basic has cadres and health clinic to serve community arround	•Workshop for developing a workplan in Building Services and Logistics Capabilities in underserved areas of West Java and South Sulawesi. •Develop curriculum and modul for ULM, MLM and PLM and private sector staff training •ULM Training •MLM Training • PLM Training •Private Sector Staff Training •Cadres/Community Leaders' Training im 2 Provinces •Supportive Supervision •Develop media campaign •Home visit / counseling by the cadres / motivator at village level •Overall project achievement	•Detailed implementation plan on EPI and MCH program developed •Training Curriculum and Modul available •35 ULM staffs trained in 2 provinces • 70 MLM staffs trained in 10 district •645 PLM staffs trained in 2 provinces, 10 district staffs trained • 1,760 PSS staffs trained in 2 provinces •1.280 Cadres/TOM in 2 provinces •Supportive supervision checklist developed •10.000 t-shirt, 2.000 banner, 2.000 leaflet, 2.000 pin. •12.800 household with babies, children and pregnant women counseled •Final report on increased utilization of EPI and MCH services in underserved areas in West Java and South Sulawesi. •Immunization Coverage increased by 10%
Gerakan Pramuka (Participatory Orientation; National Operation)	Pramuka is peer group organization has main objective to improve health knowledge by Saka Bakti Husada	•Training of Implementation for instructors in Increasing Immunization and MCH service; Provincial level with participants from Pangkep, Maros, Jayapura, Keerom, Manokwari and Sorong. •ToT for district trainers in 10 distric ts •Training on Increasiing Immunization Coverage through peer group activities for rovers and senior rovers in 10 districts: Maros, Pangkajene islands, Cilegon, Tangerang, Mimika, City of Jayapura, Sorong, Manokowari, Depok and Majalengka. •Community education by Cub Scout Scoy Troop, Rover, and Senior Rover •Monitoring and Evaluation	•Each district assigns 25 people 200 trainers from 10 districts develop knowledge and skills on immunization and MCH as well as health promotion. 2,000 scouts in 10 districts are trained • 8,000 families / community have knowledge and • Quarterly project status available.
TP PKK (Women Empowerment Orientation; National Operation	Most of cadres at posyandu are PKK members. The duty of cadres are giving information/counseing about MCH and persuading communit come to posyandu	Increasing health promotion in 3 provinces (West Java, Papua and West Papua) •Health promotion in village level in 3 villages (Jabar, Papua dan Papua Barat) •Midterm review of GAVI CSO PKK activities • Monitoring and evaluation •Endline data survey on routine immunization and MCH service after the completion of GAVI CSO activities •Final report	PKK cadres in sub district level has increased their capacity to give health counseling and mobilize community to increase routine immunization and MCH service coverage. Cadres in village level to increase routine immunization and MCH service coverage. Identification of progress, and issues as well as solutions on PKK's program implementation. Identification if the trained cadres use the right methodology to implement the activities community counselled is the right target audience. Endline data survey available GAVI CSO's financial report available.

10.2.2. **Future of CSO involvement to health systems, health sector planning and immunisation**

Please describe CSO involvement to future health systems planning and implementation as well as CSO involvement to immunisation related activities. Provide rationale and summary of plans of CSO engagement to such processes including funding options and figures if available.

If the country is planning for HSFP, please describe CSO engagement to the process.

CSO was not included in the HSFP.

10.2.3. Please provide names, representatives and contact information of the CSOs involved to the implementation.

Full name

Position

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10.2.4. **Receipt and expenditure of CSO Type B funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2011 year

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	0	0

Remaining funds (carry over) from 2010 *(B)*	692,739	7,613,180,295
Total funds available in 2011 *(C=A+B)*	692,739	7,613,180,295
Total Expenditures in 2011 *(D)*	641,464	7,049,673,968
Balance carried over to 2012 *(E=C-D)*	51,275	563,506,327

Is GAVI's CSO Type B support reported on the national health sector budget? **Yes**

Briefly describe the financial management arrangements and process used for your CSO Type B funds. Indicate whether CSO Type B funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of CSO Type B 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 HSCC in this process.

The type B fund was included in national planning and budgeting. The type B fund was channeled to 4 CSOs (IBI, Consortium, PKK and Pramuka) and to secretariat management of GAVI CSO in Center for Health Promotion. But in 2011, was channeledonly to 2 CSOs, IBI and Consortium (because PKK and Pramuka had completed phase 1 activities in 2010 and were waiting for phase 2 fund transfer)). Each CSOs must submit the financial report every 3 months to the center for health promotion through secretariat management of GAVI CSO. The bank used by the secretariat management is Bank Negara Indonesia 46 (BNI 46), while other 4 CSOs uses diferent bank,, Pramuka uses Mandiri bank, PKK uses BNI 46 Bank, Consortium uses BRI Bank, and IBI uses BNI 46 Bank.

Detailed expenditure of CSO Type B funds during the 2011 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2011 calendar year **(Document Number)**. Financial statements should be signed by the principal officer in charge of the management of CSO type B funds.

Has an external audit been conducted? Yes

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

10.2.5. **Monitoring and Evaluation**

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

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

Table 10.2.5: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
CHP 1.CSO Coordinating meeting	Availability of attendants	Centre for Health Promotion	N.A	Accompplished	June 2011	2	June 2011
CHP 2.GAVI Newsletter	Availability of guidance	Centre for Health Promotion	N.A	Accompplished	Sept 2011	2	Dec 2011
CHP 3.Monitoring and Evaluation (Monev)	Monev report available	Centre for Health Promotion	N.A	Monev in South Sulawesi	July 2011	1	July 2011
cons 1.Working Group Meeting	Coordination Meeting of the Working Group Phase II	Consortium report	N.A	Accomplished for 2011	Oct 2010 – Oct 2011	100	Oct 2013
cons 10.Executive level staff training private sec	-Increased knowledge and skills of Private Office	Consortium report	N.A	450 trainers (25,6 %)	Sept 2011	1760	July 2013

cons 11.Supportive Supervision Implementation	Frequency of monthly supervision	Consortium report	N.A	Accomplished for 2011	Dec 2011	100	Dec 2013
cons 12.Monitoring Evaluation	4 times a consolidated monitoring the implementati	Consortium report	N.A	Accomplished for 2011	Nov 2011	100	Dec 2013
cons 13.Cadre training,Village level;TOM	Trained 1280 people motivator/cadre about routine	Consortium report	N.A	212 trainers (16,56 %)	June July August 2011	1280	June 2013
cons 14.Media Dissemination / Public Campaign	Media campaign distributed :	Consortium report	N.A	Produced and distributed - 2000 Leaflet (100 %)	August 2011	100	Oct 2012
cons 15.Media Dissemination / Public Campaign	10,000 T shirt,	N.A	N.A	1000 T-Shirt (10 %)	N.A	10000	N.A
cons 17.Media Dissemination / Public Campaign	2,000 Banners,	N.A	N.A	1,600 Banners (80 %)	N.A	2000	N.A
cons 18.Media Dissemination / Public Campaign	2,000 Pins	N.A	N.A	2000 Pins (100 %)	N.A	2000	N.A
cons 2.Beginning& End of Data Collection routine	-Availability of data End routine immunization co	District health office data. Qualitative data	N.A	Accomplished for begginning of data collection	Nov 2010	100	Sept 2013
cons 3.Sosialization &Workshop at the center&Region	Socialized GAVI CSO Consortium Program in South Su	Consortium report	N.A	Accomplished	Nov 2010	100	Nov 2010
cons 4.Preparation of Integrated Training Modules	Establishment of integrated training modules on ro	Consortium report	N.A	Produced and distributed	July 2011	1500	August 2012
cons 5.Supervise preparation of the instrument of	Ceklist preparation of supportive supervision	Consortium report	N.A	Accomplished	Oct 2011	100	Oct 2011
cons 6.Doubling test IEC	Produced and distributed 10,000	Consortium report	N.A	20 % of 10000	August 2011	10000	Dec 2012
cons 7.Training Leader/manager Provincial Level Up	35 people trained and skilled about routine immuni	Consortium report	N.A	35 trainers (100 %)	May 2012	35	May 2011
cons 8.Training Leader/Manager District Secondary	70 middle-level managers to increase their knowled	Consortium report	N.A	70 trainers (100 %)	May 2011	70	May 2011
cons 9.Training of health centre personnel/traini	-Increased knowledge and skills of health center	Consortium report	N.A	267 trained in 4 district	June 2011	645	Oct 2012
cons16.Media Dissemination / Public Campaign	2,000 leaflets,	N.A	N.A	2,000 leaflet (100 %)	N.A	2000	N.A

IBI 1.Baseline survey	Immunization and MCH services baseline data is ava	Districts health office report • Qualitative stu	N.A	Completed	Oct-Dec 2010	100	Dec 2010
IBI 10.Dissemination of IEC	N.A	N.A	N.A	T-shirt 500 pcs (18,5%)	N.A	2700	N.A
IBI 11.Dissemination of IEC	N.A	N.A	N.A	Flipchart 500 pcs (100%)	N.A	500	N.A
IBI 12.Community Outreach	Posyandu coaching meeting by midwives and cadre.	IBI Report	N.A	N.A	N.A	100	N.A
IBI 13.Community Outreach	Monthly meeting and technical couching in Posyandu	N.A	N.A	N.A	N.A	100	N.A
IBI 14.Community Outreach	Community elucidation by midwives/nurses	N.A	N.A	50 Community elucidation in Bogor,	Oct 2011	930	April 2013
IBI 15.Community Outreach	Home visit elucidation by cadre	N.A	N.A	2500 Home visit	Oct 2011	21250	April 2013
IBI 16.Community Outreach	N.A	N.A	N.A	100 village level	N.A	365	N.A
IBI 17.Community Outreach	Socialization activities through meeting, program	N.A	N.A	Socialization and Advocacy in 20 sub districts	Sept 2011	73	Dec 2012
IBI 18.Endline survey	Data on immunization coverage	Districts health office report	Baseline data survey	Not yet	Not yet	100	June 2013
IBI 19.Endline survey	N.A	Qualitative study	N.A	N.A	N.A	100	N.A
IBI 2.Trainings	ToT for midwives and nurses from provincial and re	IBI Report	N.A	18 trainers from central and provincial level	May 2011	18	May 2012
IBI 20.Endline survey	N.A	IBI	N.A	N.A	N.A	100	N.A
IBI 3.Trainings	N.A	N.A	N.A	25 trainers from regency level	N.A	25	N.A
IBI 4.Trainings	365 midwives and nurses in regency level are train	N.A	N.A	511 midwives and nurses in regency trained.	June – July 2011	365	July 2011
IBI 5.Trainings	cadres and accousheuses in sub district level	N.A	N.A	250 Cadres in sub district level trained.	Oct 2011	1825	Dec 2012
IBI 6.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	Pocket book 5000 pcs (100%)	Oct 2011	5000	Dec 2012
IBI 7.Dissemination of IEC	N.A	N.A	N.A	Leaflet 2000 pcs (9%)	N.A	22000	N.A
IBI 8.Dissemination of IEC	N.A	N.A	N.A	Poster 2000 pcs (100%)	N.A	2000	N.A
IBI 9.Dissemination of IEC	N.A	N.A	N.A	Pin 1000 pcs (4.8%)	N.A	21000	N.A

Planned activities :

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

Monitoring Mechanism:

Each CSO conducts self monitoring of the activities and results through the indicators and mechanisms stated on the implementation manual, while CSO liaison officer within the Implementing Agency monitors the activities and results based on the reports submitted byCSO at the end of each financial term as well as supervisory activities andregular meetings thus develops monthly and quarterly reports. HSCC/Secretariat/TechnicalTeam monitor the activities and results of CSOs in the project area throughquarterly reports, supervision, team meetings and national meeting (mid and end of project). Feedback will be delivered directly after the data was analyzed.

The main activitieswill be monitored are:

- Training (capacity building) activities
- Health education (community outreach) activities
- Impact of the project activities

At the end theproject will be conducted and overall evaluation which evaluates input, process, output and outcome aspect.

In Consortium, the problem encountered is the limited number of Private Sector Staffin district level. So it is difficult to find participants for joining Private Sector Staff (PSS) training according a work plan.

11. 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

12.1. Annex 1 – Terms of reference ISS

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 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

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 2011	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.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

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 2011	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.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

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 2011	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

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Signature of MoH and MoF.pdf File desc: File description... Date/time: 5/22/2012 8:12:05 AM Size: 646623
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature of MoH and MoF.pdf File desc: File description... Date/time: 5/22/2012 8:12:05 AM Size: 646623
3	Signatures of members of ICC	2.2	✓	HSCC_signature.PDF File desc: File description... Date/time: 5/21/2012 11:55:06 PM Size: 1791750
4	Signatures of members of HSCC	2.3	✗	HSCC_signature.PDF File desc: File description... Date/time: 5/22/2012 12:30:02 AM Size: 1791750
5	Minutes of ICC meetings in 2011	2.2	✓	HSCC Minutes Meeting 2011_1.pdf File desc: File description... Date/time: 5/21/2012 4:12:28 AM Size: 1624182
6	Minutes of ICC meeting in 2012 endorsing APR 2011	2.2	✓	HSCC Minutes Endorsement 2012_1.pdf File desc: File description... Date/time: 5/21/2012 4:14:59 AM Size: 1068535
7	Minutes of HSCC meetings in 2011	2.3	✗	HSCC Minutes Meeting 2011_1.pdf File desc: File description... Date/time: 5/21/2012 4:16:56 AM Size: 1624182
8	Minutes of HSCC meeting in 2012 endorsing APR 2011	9.9.3	✗	HSCC Minutes Endorsement 2012_1.pdf File desc: File description... Date/time: 5/21/2012 4:16:56 AM Size: 1068535
9	Financial Statement for HSS grant APR 2011	9.1.3	✗	HSS FINANCIAL STATEMENT_1.pdf File desc: File description... Date/time: 5/21/2012 4:25:22 AM Size: 2385355
10	new cMYP APR 2011	7.7	✓	cMYP- ENGLISH.doc File desc: File description... Date/time: 5/21/2012 4:34:39 AM

				Size: 2315776
11	new cMYP costing tool APR 2011	7.8	✓	cMYP_Costing_Tool.xls File desc: File description... Date/time: 5/21/2012 4:37:49 AM Size: 3571200
12	Financial Statement for CSO Type B grant APR 2011	10.2.4	✗	financial statement Type B.docx File desc: Financial statement CSO Type B Date/time: 5/21/2012 10:29:55 PM Size: 2557104
13	Financial Statement for ISS grant APR 2011	6.2.1	✗	Financial Statement ISS 2011.pdf File desc: File description... Date/time: 5/22/2012 5:31:13 AM Size: 720963
15	EVSM/VMA/EVM report APR 2011	7.5	✓	EVM_report-Indonesia-2011 v4.docx File desc: File description... Date/time: 5/21/2012 4:09:39 AM Size: 3560945
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	EVM-imp-plan-Indonesia 2011 v3.xlsx File desc: File description... Date/time: 5/21/2012 4:10:06 AM Size: 94834
19	External Audit Report (Fiscal Year 2011) for ISS grant	6.2.3	✗	Independent Auditor Report for ISS HSS and CSO.pdf File desc: File description... Date/time: 5/22/2012 8:20:25 AM Size: 924824
22	External Audit Report (Fiscal Year 2011) for HSS grant	9.1.3	✗	Independent Auditor Report for ISS HSS and CSO.pdf File desc: File description... Date/time: 5/22/2012 8:20:25 AM Size: 924824
23	HSS Health Sector review report	9.9.3	✗	HSCC Minutes Meeting 2011_1.pdf File desc: File description... Date/time: 5/21/2012 4:42:42 AM Size: 1624182
24	Report for Mapping Exercise CSO Type A	10.1.1	✗	Mapping CSO's.docx File desc: Mapping Exercise CSO Date/time: 5/21/2012 7:07:25 AM Size: 30998
25	External Audit Report (Fiscal Year 2011) for CSO Type B	10.2.4	✗	Independent Auditor Report for ISS HSS and CSO.pdf File desc: File description... Date/time: 5/22/2012 8:20:25 AM

				Size: 924824