GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

Indonesia

Reporting on year: **2012**
Requesting for support year: **2014**
Date of submission: **15/05/2013**

Deadline for submission: 24/09/2013

Please submit the APR 2012 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: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
INS			

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

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 2012	Request for Approval of	Eligible For 2012 ISS reward
VIG	No	No	N/A
COS	No	No	N/A
ISS	Yes	next tranche: N/A	N/A
HSS	Yes	next tranche of HSS Grant Yes	N/A
CSO Type A	Yes	Not applicable N/A	N/A
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2012: N/A	N/A
HSFP	No	N/A	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 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. Desak Made Wismarini, MKM	**Name**	Ayu Sukorini
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	+62811909795	tsandra_dratih@yahoo.co.id
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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

N/A	N/A		

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), May 14, 2013 , 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
Jane Soepardi	Director of Child Health		
Isthi Retna Ningsih	Chief of Finance Devision on DG MCH		
Yenny Yuliana	Directorate of Child health		
Bardan Jung Rana	WHO		
Asmaniar	WHO		
M. Syahjahan	WHO		

Lily S Sulistyowati	Health Promotion Center		

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
REZEKI, Bea	Financial and Development Audit Body		
SIMANJUNTAK, Binsar	Finance and Development Audit Body		

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
Jane Supardi	Director of Child Health		

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 2012 and specifies the requests for the period of January – December 2014

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Total births	0	4,669,125	0	4,738,692	0	4,809,304	0	0
Total infants' deaths	0	140,071	0	142,155	0	144,279	0	0
Total surviving infants	0	4,529,054	0	4,596,537	0	4,665,025	0	0
Total pregnant women	0	5,136,041	0	5,212,568	0	5,290,235	0	0
Number of infants vaccinated (to be vaccinated) with BCG	0	4,582,526	0	4,501,757	0	4,809,304	0	0
BCG coverage	0 %	98 %	0 %	95 %	0 %	100 %	0 %	0 %
Number of infants vaccinated (to be vaccinated) with OPV3	0	4,523,675	0	4,136,883	0	4,291,823	0	0
OPV3 coverage	0 %	100 %	0 %	90 %	0 %	92 %	0 %	0 %
Number of infants vaccinated (to be vaccinated) with DTP1	0	4,593,504	0	4,366,710	0	4,665,025	0	0
Number of infants vaccinated (to be vaccinated) with DTP3	0	4,489,411	0	4,366,710	0	4,665,025	0	0
DTP3 coverage	0 %	99 %	0 %	95 %	0 %	100 %	0 %	0 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	1	0	1	0	1	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.01	1.00	1.01	1.00	1.01	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	0	4,424,364	0	4,136,883	0	4,291,823	0	0
Measles coverage	0 %	98 %	0 %	90 %	0 %	92 %	0 %	0 %
Pregnant women vaccinated with TT+	0	3,628,465	0	4,170,054	0	4,232,188	0	0
TT+ coverage	0 %	71 %	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	0	0	0	0	0	0	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	2 %	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 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 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**

  In 2012, at the first time, we used denominator issued by the General Secretary of Ministry of Health to measure our program achievement including in JRF 2012. Previous years, we used administrative data issued by district and provincial.

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

  Started in this year, we used the number of surviving infants as denominator of antigens which are given to children at more than one month of age. Just like the number of births, we used data of the General Secretary's Decree.

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  There are no changes.

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

  Open vial management has been applied at health facilities for DPT-HB, TT or Td

5.2. Immunisation achievements in 2012

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 2012 and how these were addressed:

All of our coverages in 2012 have been increased and reached the targets (coverage of BCG : 98%, HB birth dose :84%, OPV3 : 97%, DPT-HB1: 98%, DPT-HB3: 96% and Measles : 98%). In terms of denominator, there was a different with 2011, since 2012, we use live births number for denominator of HB (< 7 days), BCG and OPV1, while other antigens use surviving infants number as the denominator.

In this year, we had Mid Level Manager (MLM) training. The participants were the immunization program officers from 11 provinces and 36 selected districts (low performance districts).We also conducted EVSM (Effective Vaccine Storage Management) in 8 provinces, EVM (Effective Vaccine Management) in 18 provinces and DQS (Data Quality Self Assessment). The EVSM assessment will be replaced by EVM assessment, start from 2013. The report of EVM assessment result in 2012 is attached.

2012 has been declared as The Year of Intensification of Routine Immunization(IRI). Therefore, we conducted some activities such as coordination meeting in central level (where interprograms and intersectors were invited) to synchronize attempts on immunization program implementation, technical assistance visits to provinces, socialization meetings in provinces (interprograms and intersectors were invited) and advocacy meetings. Socialization meetings were aimed to identify problems and obstacles in immunization program implementation insome areas and work together to find the solutions. Moreover, we conducted advocacy meetings in Tasikmalaya and Majalengka District, West Java, to persuade religion leaders, community leaders, interprograms and intersectors to give accurate information about immunization to community/parents especially in terms of halal/haram issue. We also distributed IEC materials such as t-shirts, caps, posters,and leaflets to socialize the IRI to provinces and districts.

In order to control diphteria outbreak in East Java, we had implemented Supplementary Immunization Activities (SIAs). Firstly, we conducted preparation meeting in province level, then followed by technical assistance visits during implementation. We divided the target into 3 age groups who were given different antigens : 1) 3 years old and less (DPT-HB vaccine), 2) between 3 and7 years old (DT vaccine) and 3) between 7 and 15 years old (Td vaccine). The Rapid Convenient Assessment (RCA) also carried out to monitor and evaluate this activity. The SIA was conducted in 18 districts with coverage was very high,more than 95% for all antigens (DPT : 97.6%, DT : 99.8% Td : 99.8%).

To increase immunization coverage in low performance areas, we had conducted DOFU (Drop Out Follow Up) which was implemented in 58 districts in 13 provinces. We had also implemented training on immunization program management for hospital officers in 3 provinces (West Java, Banten and South Sulawesi) and comprehensive training on immunization and MCH program management for health center staff in Riau Islands and Bengkulu. These 3 activities was funded by HSS Reprogramming funds.

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

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
Demography and Health Survey	2012	73.1	70.9

Basic Health Survey	2010	62.1	61.7

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

There were no discrepancies in vaccinating boys and girls, all got the same opportunity to be vaccinated. For reporting and recording system, we already have a new RR form which is divided by gender and plan to implement this in 2013.

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Not selected**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

There were no such barriers related to gender in immunization program implementation in Indonesia.

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)

As it was happened in the previous years, in 2012, there were also differences between the administrative coverage and survey coverages such as Demography Health Survey 2012 and Basic Health Survey 2010.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **Yes**

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

In 2011, we had conducted Data Quality Self-assessment (DQS) in 7 provinces (North Sumatera, Bangka Belitung, Banten, North Maluku, East Nusa Tenggara, West Sulawesi, and West Papua) and had assessed 28 health centers and 66 villages. Whereas, in 2012, we conducted DQS in 8 provinces (Aceh, Bengkulu, West Sumatera, East Java, DI. Yogyakarta, Bali, North Sulawesi and Gorontalo) and visited 32 health centers and 64 villages. We use DQS assessment as a tool to identify data quality in health centers, districts and provinces, and the result will be used for program improvement. We can see the DQS result in 2012 below.

A. Quantity

1. DataAccuracy

Levels

BCG

DPT/HB3

Measles

Villages to Health centers

14.0%

14.0%

16.0%

Health centers to Districts

50, 0%

47.0%

45.0%

Districts to Provinces

81.25%

75.0%

87.5%

Data accuracy is determined from the lowest level. Theaccuracy from villages to districts for 3 antigens were low (below 20%). Lowaccuracy of the data was caused by several things including the use ofnon-standard recording books and also because the health workers were notdirectly record immunized children after immunization session.

2. Overreporting

Levels

BCG

DPT/HB3

Measles

Villages to Health centers

68%

68%

68%

Health centers to Districts

34%

3 1%

32%

Districts to Provinces

12.5%

18.75%

6.25%

3. Underreporting

Levels

BCG

DPT/HB3

Measles

Villages to Health centers

1 8%

18%

18%

Health centers to Districts

1 6%

22%

23%

Districts to Provinces

6.25%

6.25%

6.25%

B. Quality

Aspects	
Health Center	
District	
Province	
Recording	
	60.7%
	66.7%
	66.7 %
Reporting	
	59.5%
	56.6%
	61.0 %
Demography	
	65.9%
	64.3%
	67.1 %
Data utilization	
	50.8 %
	46.0%
	49.0 %
Forms and data avilability	
	65.1 %
	66.7%
	76.2 %

According to the table above, we can see that on average, it was about 60% of health centers,districts and provinces had a good data quality. Attempts to improve data quality in provinces, districts and health centers are still needed. Therefore, we are developing web-based immunization reporting and recording system which give us individual data, not aggregate data and also more accessible.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

Attempts to improve administrative data system were :
1. We re-developed the Local Area Monitoring software for recording and reporting. In our new software, we divided targets into 2 (live births and surviving infants) and also separated the data by gender.
2. We introduce web-based immunization RR system to avoid double recording
3. We conduct DQS every year in selected areas to assess data quality
4. We conduct suportive supervision every year in selected areas as one of the way to give "on-the-job-learning" to the province, district and health center officers and also cadres about reporting and recording system.

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.

- We have introduced web based immunization RR system in 4 provinces (DI. Yogyakarta, West Java, Bali and Central Java) and it will be expanded to Riau Islands province in 2013
- We link our web based RR system with the Health Information System developed by Center of Data and Information, MoH which is covering all health centers in Indonesia
- We conduct DQS regularly

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** 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$ = 11339.9	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 2012**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**NA**	**NA**	**NA**
Traditional Vaccines*	49,742,566	49,742,566	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)	4,824,805	4,824,805	0	0	0	0	0	0
Cold Chain equipment	3,261,871	3,261,871	0	0	0	0	0	0
Personnel	1,745,531	1,589,372	0	65,547	90,612	0	0	0
Other routine recurrent costs	417,471	291,278	68,006	44,012	14,175	0	0	0
Other Capital Costs	3,950	3,950	0	0	0	0	0	0
Campaigns costs	0	0	0	0	0	0	0	0
Provincies and Districts Budget		540,000,000	0	0	0	0	0	0
Total Expenditures for Immunisation	59,996,194							
Total Government Health		599,713,842	68,006	109,559	104,787	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.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

Country expenditure consist only state budget, we could not identified provinces and district budget for immunization.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Yes, fully implemented**

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?
Within 3 months of the effective date of this Aide Memoire, the Secretariat of Integrated Immunization Program of MoH shall submit to the GAVI Alliance Secretariat a plan, as approved by the HSCC, for improved interaction between the responsible Directorates of the MoH and the Secretariat of Integrated Immunization Program of MoH as well as the HSCC, to liase with, and pursue, actions agreed to by respective officials in the MoH for programme implementation	Yes
The MoH shall bring GAVI funds into the GOI state budget preparation process by completing, during the financial year 2010/11 and in subsequent financial years, the process of registration of GAVI funds with the Directorate General of Debt Management, MoF	Yes
Within 3 months of the effective date of the Aide Memoire and prior to any disbursements being made by GAVI, MoH shall provide written confirmation to the GAVI Alliance Secretariat that it has obtained the approval of the Ministry of Finance, in accordance with GOI regulations which require that funds transferred directly to the MoH, shall be placed in a bank account approved by the MoF	Yes
Further disbursements of GAVI cash grants to provincial and district health offices shall be through the above MoF approved central bank account in the name of MoH and use electronic transfers to banks at provincial and district level	Yes
Within 3 months of the effective date of this Aide Memoire, the Head of the Secretariat of Integrated Immunization Program of MoH and the Budget authorised user shall jointly submit to the GAVI Alliance Secretariat written confirmation that a qualified and experienced accountant to assist for the financial management of all GAVI cash grants to Indonesia has been appointed	Yes
In addition, the Secretariat of Integrated Immunization Program of MoH and staff responsible for, or involved in, the financial management of GAVI supported programmes at provincial and district levels shall undergo basic training in financial management, to include budgeting, accounting and book-keeping, internal control and financial reporting	Yes
The Secretariat of Integrated Immunization Program of MoH, by bringing GAVI funds into the GOI state budget preparation process (as per point 1 above) will be subject to all of the internal controls of the prevailing financial rules and regulations	Yes
Within 3 months of the effective date of this Aide Memoire, the Secretariat of Integrated Immunization Program of MoH shall submit to the GAVI Alliance Secretariat a financial management manual which details financial management arrangements for planning, budgeting, accounting, internal control, financial reporting, internal and external audit of MoH and which is in keeping with existing GoI financial rules and regulations, in particular Government Regulation 60/2008 on Government Internal Control System	Yes
Bringing GAVI funds 'on budget' will ensure that they are within the purview and scope of the Inspector General of Internal Audit of the MoH and, where relevant, the BPKP	Yes
Within 3 months of the effective date of this Aide Memoire and prior to further disbursements of cash grants, the Secretariat of Integrated Immunization Program of MoH shall submit to the GAVI Alliance Secretariat a full management response (in English) to the recent audit conducted by BPKP on the financial accounts produced for years 2008 and 2009	Yes
Within 3 months of the effective date of this Aide Memoire and prior to further disbursements of cash grants, the Secretariat of Integrated Immunization Program of MoH shall confirm in writing to the GAVI Alliance Secretariat that the Independent audit of all GAVI supported programmes for the current financial year and any future financial years shall be undertaken by BPKP	Yes
The MoH GAVI Secretariat shall obtain annual independent audit reports, within 6 months of the financial year end, for each CSO that receives cash support and provide copies of these to the GAVI Alliance Secretariat	Yes
Following the signing of this Aide Memoire and the delivery of documents specified in Sections 3,8,10 and 11 of this Aide Memoire, the GAVI Alliance Secretariat may make disbursements of cash grants to the designated bank account	Yes

Further future disbursements will be released based on satisfactory progress against all of the measures described above in addition to the regular obligations associated with completion of the Annual Progress Reports for all GAVI grants	Yes

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

The action plan from Aide memoire has been fully 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 2012? **1**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 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 merged with HSCC since 2011.

The latest HSCC meeting was held on April 18, 2013 with the result as below :

1. Approved a new indicator that refers to the objective of reprogramming

2. HSCC team has approved the resubmit of APR 2011 on 18 April 2013 by attaching the new indicator in accordance with the reprogramming objectiveand also target of the indicators

3. Approved the use of MCH HSS remaining funds for support costs and provide details of activities

4. NVS team will be established and will have role to make a report to the Minister of Health and to coordinate with the Directorate of Public Medicine, Directorate General of Pharmaceutical and

Medical Devices;

5.Technical meeting with Financial and Development Audit Body or Badan Pengawasan Keuangan Pembangunan (BPKP) regarding the audit result and APR 2012 submission will be conducted on May 10, 2013

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

If Yes, which ones?

List CSO member organisations:
Women Movement

5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

According to the comprehensive Multi Year Plan (cMYP) 2010-2014, our main objectives and priority actions are :

- To achieve 95% UCI coverage in 2013 and 100% by the end of 2014
  - EPI RR web based implementation in 6 provinces in Java in 2013 and 10 provinces in Sumatera in 2014
- To achieve 80% or more Hepatitis B birth dose coverage in 2014
- To increase second dose measles coverage to 95% or more for school-age children
  - Coordination and integration with other sectors/ programs in school-age children immunization implementation
- To achieve the elimination of Maternal and Neonatal Tetanus
  - Strengthening program by integrated activities of EPI and MCH to maintain the MNTE status
- To maintain 100% AD syringes usage
- To develop and implement national policy on waste management.
  - Reaching standard waste disposal management implementation in 75% districts in 2013 and 100% districts in 2014
- To introduce new vaccines (Hib, JE and Pneumococcal vaccines).
  - Hib new vaccine introduction (pentavalent) will start in 2013

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 2012

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
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)

We have included injection safety in our new guideline, the Health Minister's Decree about Immunization Program Management, which is still in process to be approved by the Minister and have also developed the Standard Operational Procedures of immunization including safe injection. Most provinces and districts had trained their staff also. However, the issue of high turn-over of health workers was still exist.
Therefore, GoI conducted monitoring activities to ensure that the safe injection practice was well implemented. We also cooperated with Badan PPSDM (Health Human Resources Development Body, MoH) to include immunization lecture in curriculum of health school institutions.

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

Sharps waste management policy is already available, include in our new guideline, the Health Minister's Decree about Immunization Program Management which is still waiting for approval.
There are several ways in managing infectious sharps waste :
1. Using incinerator
2. Using concrete basin
3. Using needle cutter or needle destroyer (for the syringes only)

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	0	0
Remaining funds (carry over) from 2011 *(B)*	130,810	1,483,368,511
Total funds available in 2012 *(C=A+B)*	130,810	1,483,368,511
Total Expenditures in 2012 *(D)*	68,006	771,168,610
Balance carried over to 2013 *(E=C-D)*	62,804	712,199,901

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.

In 2012, we only used the ISS remaining funds carried over from 2011 which was $147,755 with detail process as explained below :

According to the Minister ofFinance's Decree No. 191/PMK.05/2011 about Grant Management Mechanism, GAVIgrant should be approved by Country General Treasurer. The 2011 ISS fund had been approved with following steps :
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) in our national health budgeting
4. Directly Grant approval in terms of money and expenditure

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 2012, we used the 2011 remaining funds only for central level, we did not distribute the funds to provinces and districts.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2012

Major activities that have been conducted to strengthen immunization using ISS funds in 2012 were :
1. Technical assistance visits to provinces, this was aimed to increase the UCI coverage through some activities such as suportive supervision.
2. Coordination meeting in central level where interprograms and intersectors were invited, to synchronize attempts on immunization program implementation
3. Advocacy meetings, were conducted in Tasikmalaya and Majalengka District, West Java to persuade religion leaders, community leaders, interprograms and intersectors to give accurate information about immunization to community/parents especially in terms of halal/haram issue
4. Preparation meeting and monitoring activities of SIA in East Java (to control diphteria outbreak)

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 2012 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2012 calendar year (Document Number 7) (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 8).

6.3. Request for ISS reward

Request for ISS reward achievement in Indonesia is not applicable for 2012

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

Indonesia is not reporting on New and Under-used Vaccines Support (NVS) fund utilisation in 2013

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2012 vaccinations against approvals for 2012

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level 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)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

7.2.3. Adverse Event Following Immunization (AEFI)

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

Does your country conduct special studies around:

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)		
Remaining funds (carry over) from 2011 (B)		
Total funds available in 2012 (C=A+B)		
Total Expenditures in 2012 (D)		
Balance carried over to 2013 (E=C-D)		

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 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 2013 onwards

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
	Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	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

If yes, provide details

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

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 2013

Renewal of multi-year vaccines support for Indonesia is not available in 2013

7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

If you don’t confirm, please explain

7.11. Calculation of requirements

8. Injection Safety Support (INS)

This window of support is no longer available

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 2012**. All countries are expected to report on:

   a. Progress achieved in 2012

   b. HSS implementation during January – April 2013 (interim reporting)

   c. Plans for 2014

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

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, 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 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. 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 2013, the HSS reports are expected by GAVI Alliance by September 2013.

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 objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

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 2012

   b. Minutes of the HSCC meeting in 2013 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2012 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 2012 and request of a new tranche

Please provide data sources for all data used in this report.

9.1.1. Report on the use of HSS funds in **2012**

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: **9420500** US$

These funds should be sufficient to carry out HSS grant implementation through December 2014.

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*)	0	7961000	16866397	0	0	7691000
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	16866397	0
Total funds received from GAVI during the calendar year (*A*)	0	7691000	270000	0	0	3723000
Remaining funds (carry over) from previous year (*B*)	0	0	6443193	6379889	2650174	1380130
Total Funds available during the calendar year (*C=A+B*)	0	7691000	6713193	6379889	2650174	5103130
Total expenditure during the calendar year (*D*)	0	0	333304	3729195	1537530	2445816
Balance carried forward to next calendar year (*E=C-D*)	0	7691000	6379889	2650174	1112644	2657314
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	7691000	16866397	0	0	7691000	0

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	2657314	0	0	0
Total Funds available during the calendar year (*C=A+B*)	2657314	0	0	0
Total expenditure during the calendar year (*D*)	2040864	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	658780	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	3723000	9420500	0	0

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	0	75629420	191261400	0		75629420
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	191261400	0
Total funds received from GAVI during the calendar year (*A*)	0	73064423	3061743	0	0	34035666
Remaining funds (carry over) from previous year (*B*)	0	0	73064455	72346601	30052416	12617148
Total Funds available during the calendar year (*C=A+B*)	0	73064423	76126198	72346601	30052416	46652814
Total expenditure during the calendar year (*D*)	0	0	3779597	42294184	17435267	22359650
Balance carried forward to next calendar year (*E=C-D*)	0	73064423	72346601	30052416	12617149	24293163
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	75629420	191251400	0	0	75629420	0

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0
Remaining funds (carry over) from previous year (*B*)	24293163	0	0	0
Total Funds available during the calendar year (*C=A+B*)	24293163	0	0	0
Total expenditure during the calendar year (*D*)	18270595	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	6022568	0	0	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	86122211	0	0

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	11339.79	9142
Closing on 31 December	9499.99	11339.79	11339.79	11339.79	11339.79	9142

Detailed expenditure of HSS funds during the 2012 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2012 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: 19)**

If any expenditures for the January April 2013 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: 20)**

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.

note for Table 9 :

* thedifference between the balance at the end of 2008 (7,691,000) and the amountcarried forward to 2009 (6,443,193) is due to the exchange rate between USD andIDR. However the IDR amount of the balance and the amount carried forward isthe same (73,064,452,500).

** thedifference between the balance at the end of 2011 (1,112,644) and the amountcarried forward to 2012 (1,380,130) is due to the exchange rate between USD andIDR. However the IDR amount of the balance and the amount carried forward isthe same (30,052,415,079).

***Table 9.1.3b (Local currency) in thousand because the digits in the table for the local currency is not enough

*** For table 9.6 Planned HSS activities for 2014 will be submitted together with Annual Progress Report 2012 in September 2013, because we just submit Annual Progress Report 2011 and we have not been able to plan activities in 2013

Financial management of HSS funds

After theendorsement of HSCC members at 2011, to improve HSS activities implementation, thefunds from the DG of DC and EH (the main bank account of all GAVI granttransferred off) was sent to the Secretariat of DG of Nutrition and MCH bankaccount at BNI Bank (the government account which was acknowledged by MoF).This mechanism has been stated in the new PIM and legalized by DG of DC and EHas a Project Manager of GAVI Alliance Grants.

The detailbudget of activities each year has been put at The State Budget Document since2010. In 2011, all activities have been put at the Secretariat of DG ofNutrition and MCH's State Budget Document. In 2012, the reprogrammingactivities budget has been disburse to the Secretariat of DG of Nutrition andMCH, Centre of Health Promotion, Sub-Directorate of Immunization asimplementing units, then budget statement was also put at their budgetstatement.

From theimplementing units, the budget for the sub-national activities was sent to eachprovinces and districts government bank account. This account has beenacknowledged by MoF. The head of PHO and DHO will submit their integrity pactbefore disbursement of their fund.

The standard of all cost used thenational cost standard from MoF decree which is launched each year, No100/PMK.02/2010 has been design for 2011 activities, 84/PMK.02/2011 for 2012activities, and for next year will follow decree of MoF No 37/PMK.02/2012.

the role of secretariat (SKIPI) in financial management is to coordinate the planning activities of each component, the revenue grant budget and also to analysis of financial accountability

activities in 2013 has been carried forward from 2012 which was approved to be utilized by april 2013

In 2013, the remaining funds from 2012 will be used to continue activities in 2013 and the management costs up to the month of December 2013

Untuk perencanaan 2014, just submit the APR 2011 wll IRC to cosider our in september 2013as a mention

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: 21)

9.2. Progress on HSS activities in the 2012 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 2012 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
First Tranche			
Objective 1: Community mobilized to support MCH			
1.1 Assesment and mapping of existing situation relating to community activities in the selected provinces	Village Mapping and Service Availability Mapping	100	Survey, MoH (DG of Nutrition and Maternal and Child Health)
1.2 Selection of cadress (CHWs) within their own communities and village level training of cadres using existing training materials	Cadres training of poskesdes (village health post) in West Java at 4 District to Increased ability of cadres About Maternal and neonatal Health in Effort to Increase Immunization Coverage . Improvement of cadre's capacity on neonatal health to escalate immunization coverage in 4 districts of West Java Province.	100	DHO, PHO, DG of Nutrition and Maternal and Child Health, Health Promotion Center
1.3 Development, procurement and distribution of IEC materials and equipment including MCH handbook	1. Printing publications of IMCI (Integrated Management of Sick Children-Under 5) Chart Book and distribution to 5 provinces.2. Printing of Guideline of Child Health Care for Cadre in 5 Province. 3. Printing publication of Essential Neonatal Health Service Handbook and distribution to 5 provinces. 4. IEC (Information, Education, Communication) Media (e.g. leaflet and poster of neonatal / infant health with local contents) and distribution to 5 provinces. 5. Printing publication of GAVI HSS IEC (Information, Education, Communication) material.	100	1-4 MoH (Directorate of Child Health) 5. MoH (Secretariate General of Nutrition and MCH)
1.4 Sensitization of community and religious leaders to MCH issues including immunization, and the role of cadres	1. Advocacy towards TOMA (Community Figures) / TOGA (Religious Figures) against immunization refusal in Banten Province and West Java Province. 2. Advocacy of Maternal Child Health and immunization program to religious organizations in 5 provinces	100	PHO, MoH (Directorate of Surveilance and Immunization)

Objective 2 : Management capacity of MCH personnel improved			
2.1 Needs assessment by MoH/ PHO/ DHO staff of MCH management issues at district and health centre levels	1. Meeting of GAVI tranche-2 (2012-2014) Planning in Center and Cross Sectoral / Program. 2. Meeting of GAVI Tranche-2 (2012-2014) Planning in 5 provinces 3. Meeting Drafting of POA (Plan of Action) / RKA-KL (Planning of Budget Performance – Ministry Institution) GAVI HSS. 4.Coordination Meeting to Implementation Activity GAVI HSS Reprogramming (Tranche-2).	99	PHO, MoH (Secretariate General of Nutrition and MCH)
2.2 Advocacy by MoH/POH staff to district administration and political leaders for adequate budgedtary support of MCH activities	1.Province advocacy meeting with Related Cross Sectoral from District/City to strengthen the Program of MCH and Immunization in West Java and South Sulawesi. 2. Mentoring LP/LS (Government/Private Institution) Advocacy on Immunization and MCH Program in districts.	99	PHO, MoH (Secretariate General of Nutrition and MCH)
2.3 Development and distribution of management guidelines, tools (such as supervision)	Printing of Provision of supervision tools: Monitoring and Technical Guidance.	100	MoH (Secretariate General of Nutrition and MCH)
2.4 Plan, design and conduct training of district Training Team who will give training at HC level	1. Orientation of IMCI (Integrated Management of Sick Children-Under 5) to improve immunization coverage in South Sulawesi Province. 2. Meeting of Material Drafting. 3. Test-run on leaflet and poster with local contents in Papua	100	PHO, MoH (Secretariate General of Nutrition and MCH)
2.5 The health centre team training in micro planning, supervision, M&E, surveillance and managing community development	Management Training of Puskesmas (Public Health Center).	100	DHO, PHO, MoH (BUKD)
Objective 3: Partnership formed with non-government agencies			
3.1 Identification of partners, development of action plans, formulation of MOUs	Evaluation for Sector Partners in MCH Service Delivery to 5 Provincy (central level)	100	MoH (Directorate of Maternal Health)

3.2: Strengthening coordination, implementation of MOU, including regular consultations and joint monitoring and	1.Technical Orientation on MCH Regulation Janpersal Vaccination, MCH handbook for Health Center and team midwives 2.Technical Orientation on Midwifes - TBA's Partnerships for Health Centers Team and Community Midwifes 3.Orientation on Providing Midwifes - TBA Partnership for 5 Provincies, 33 Districts/cities 4.Reguler Meeting CSOs group for Community mobilization and service delivery efforts 5.Reguler Meeting Community Midwives and TBAs in Village Level	99	DHO, PHO, MoH (Directorate of Maternal Health)
3.3: Engaging private sector partners in MCH service delivery, including orientation to government policies on MCH, and sensitization of TBAs and private midwives	Evaluation for sector partners in MCH service delivery in Provincy Level (Papua and Papua Barat)	100	PHO, MoH (Directorate of Maternal Health)
Reprogramming			
Objective 1 : Area with low immunization coverage through acceleration of immunization coverage in low coverage areas* (Reprogramming)			
Develop and distribute IEC material and social mobilize on immunization and maternal and child health with local content for the hard to reach and mountainous area of papua and west papua province	1. Create a cadre training curriculum on immunization, maternal and child health in Papua and West Java 2. Printing and distribution IEC material on Immunization, maternal and child health based on religious (all ready develop CSO)		MoH (Directorate of Child Health)
Printing & Distribution of Buku kader seri kesehatan anak, Printing of Essential Neonatal Health Care Books and caders training modules for the 5 indentified HSS province	Printing & Distribution of Buku kader seri kesehatan anak, Printing of Essential Neonatal Health Care Books and caders training modules for the 5 indentified HSS province		
Coordinative meetings and Socialization at central level for 13 Provinces and 58 districts/cities that implement Intensive Routine Immunization (IRI)		100	PHO, MoH (Directorate of Surveilance and Immunization)
Coordinative meetings and advocacies at district/cities among related cross sectors or programs of HC		100	PHO, MoH (Directorate of Surveilance and Immunization)
Routine immunization through DOFU in 58 districts/cities with low coverage in 13 provinces		100	PHO, MoH (Directorate of Surveilance and Immunization)
Immunization Public service announcement (ILM)		100	PHO, MoH (Directorate of Surveilance and Immunization)

National media workshop for 44 journalist from the 22 identified provinces (5 HSS Provinces, 10 IRI Provinces and 7 provinces in Sumatera excluding IRI provinces) to ensure public awareness. The workshop was supported by media campaign of participating provinces/districts.		100	PHO, MoH (Directorate of Surveilance and Immunization)
Objective 2 : Capacity Development on ensuring data collection and reporting			
Revise and standardize tool for reporting and recording individual resistrations (hard and soft) at health centre level			PHO, MoH (Directorate of Surveilance and Immunization)
Refreshing training and implementation of DQS at the full of the 3 provinces HSS (West Java, South Sulawesi and Banten) and 34 identified districts under IRI.		100	PHO, MoH (Directorate of Surveilance and Immunization)
Objective 3 : Improve immunization staff competency through strengthening implementation of MCH-Immunization material for midwife institution			
Review & revise the immunization and MCH component in the midwife academic curriculum & introduce in the 51 midwife in the 5 identified HSS Provinces		50	MoH (Human Resource Development Bureau)
District level technical orientation and sensitiztion of Immunization and MCH by partnering midwives and village TBA in two fo the HSS provinces of West Java and South Sulawesi.	Technical orientation to improve immunization coverage through partnerships between midwife and TBA of HCs that are located in the low immunization coverage.	100	PHO, MoH (Directorate of Surveilance and Immunization)
District level comprehensive training of the health center staff on Immunization and MCH program management in the all districts in Riau, Riau Islands, Bengkulu, West Sumatera, All Kalimantan Provinces	1. Training of immunization management for 3 hospitals in 3 provinces of Banten, West Java, and South Sulawesi 2. District level comprehensive training of the health center staff on Immunization and MCH program management in the all districts in Riau, Riau Islands, Bengkulu, West Sumatera, All Kalimantan Provinces	100	PHO, MoH (Directorate of Surveilance and Immunization)

District level training of cadres on basic immunization and maternal and child health practices in the 32 districts of the identified 4 HHS provinces - West Java: 14 district, South Sulawesi 14 District, Papua (2 District) and West Papua (2 District)	1. Cadres Training 2. Create a cadre training curriculum on immunization, maternal and child health	80	1-4 MoH (Directorate of Child Health)

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**
First Tranche	
1.1 Assesment and mapping of existing situation re	
	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 (West Java, Banten, South Sulawesi, Papua, and West Papua), covering 62 districts / cities, 1.588 Health Centers, 11,098 villages. 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). The result or information is used for the following: 1. Data and information: used as data baseline planning for GAVI's 2nd tranche 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.depkes.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 Considering the vast number of Village Mapping (VM) and Service Availability Mapping (SAM) data surveys, it is necessary make use of those data optimally, one of which is through workshops at each of GAVI HSS Provinces This is particularly useful to scoop up problems and finding solutions based on those survey data as well as from other related data which are available at GAVI HSS districts/cities. From there, new evedance – based policy may be created. Generally, the objective of workshop is to utilize the survey data of the 2010 GAVI – HSS as well as other data, in order to determine priority of problems at district/city level. The objective of the

Village Mapping and Service Availability Mapping	workshop in particular as follows: a. Make inventory of problems of MCH b. Set up priorities of MCH, including immunization coverage at district/city level, based on 2010 GAVI – HSS survey data c. Set up alternative solution of the determined problems d. Set up priority of problems based on 2010 GAVI – HSS survey data anlisys. e. Set up phase 2 GAVI – HSS according to the determined priority of problems The data used in this workshop include: targeted pregnant and partum cases, and babies. The type of data to be created is absolute data and the percentage of 4th visit, partum, 1st neonatal visit, complete neonatal visit, HB0, BCG, Polio 4, DPT3, and measles cases. From the result of overall data, the problems can be identified (focusing on each HC), by identifying the first, the second, the third problems, etc. to be then drawn the root of problems, which from there the the scale of priority is made. This scale of priority will determine any solution to be decided at each HC, to put into consideration the availability of resources at each HC. Results from 5 provinces: Workshop was carried out by the coordinator of GAVI HSS at provincial level, including team of the Min. of Health as well as the team of university that manages GAVI HSS programs. The results are as follows: - Workshop at West Java province, involving provincial level GAVI executors as well as 26 districts/cities level that were the coverage areas of VM and SAM of Gavi HSS. From this workshop, it is expected that there would be budget available for immunization advocacy, better skill of HC director and immunization coordinators, recommendation on staffing management based on work load, empowering the community, better coordination of cross sector performance regarding recording and reporting, make analysis of work load particularly on midwife, and the skill of program executor in analyzing problems as a base of making program budget. - Workshop in Banten province by involving provincial level GAVI executors and 8 districts/cities that were the coverage area of VM dan SAM - Workshop in South Sulawesi by involving provincial level GAVI executors and 12 districts/cities that were the coverage area of VM dan SAM. - Workshop in Papua province by involving provincial level GAVI executors and 3 districts/cities that were the coverage area of VM dan SAM. - Workshop in West Papua province by involving provincial level GAVI executors and 2 districts/cities that were the coverage area of VM dan SAM - For West Papua province, there is still lack of facilities at HCs, particularly in remote areas, lack of staff of immunization and MCH, lack of skill, insufficient standard of costs agreed and those available on the field. Therefore, the solution proposed is to add more facilities, more staffing, better skill particularly on immunization and MCH, adjustment of standard of costs that are enough to apply on the field.
1.2 Selection of cadress (CHWs) within their own c	

Increase the knowledge of cadres on infant health	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. Cadres' role in escalating the public participation to improve the coverage of Immunization and MCH is very strategic hence their skill must be enhanced through training or orientation. Health cadres in the village/MCH care center are volunteers who can facilitate access for community and health worker to obtain health services. In practice, cadre gives elucidation, also acts as an activator and motivator for childbearing mothers and mothers with babies; therefore it is necessary to equip and to increase the cadre's concept in infant health care. Therefore this activity is very important to be performed. The objective of this activity is the escalation of knowledge and skill of cadres and public figures in mentoring and empowering the community to improve the coverage of immunization and MCH program, and eventually skilled cadre of MCH HCs are expected to apprehend about mother's health care post birthing, neonatal health care, helping health worker in preparing target of MCH and immunization; and also cadres are able to give socialization regarding their applied training to other cadres in respective areas. Output indicators: 1. West Java Province:184 cadres trained in 4 districts. 2. South Sulawesi Province: 360 cadres trained in 5 districts 3. Banten Province : 360 cadres in 4 districts 4. Papua Province : 40 cadres in 1 district
1.3 Development, procurement and distribution of I	
1.3.1. Printing publications of IMCI (Integrated M	IMCI (Integrated Management Child Illness) chart book is a compulsory book for health workers (midwife, nurse) whom handling sick children under-5 in the health center; while for medical practitioner the chart book is needed during their orientation activity so that when a midwife/nurse refers the first patient to doctor the public health center, they will have the same perception about IMCI management. It is expected that through chart book publication from GAVI funding, it can fulfill the needs of midwife and nurse within those 5 provinces. As for the chart book provision in Central office, the book is utilized for orientation activity of IMCI chart book for public health center's MD; for facilitation activity of evaluation cluster 4 PPI (Fish Auction Dock) in fishermen area where the under-5 mortality rate is still high in 4 provinces and the population is densed; for technical guidance activity by the under-5 health program coordinator in 5 provinces. Besides, the chart book in Central office was also distributed to the coordinator of child health program in province/ district/ public health center/ health major university/ related government institution with direct consulting to the Sub-Drectorate of BKH Children Under-5 and Pre-school, Child Health Directorate
1.3.2. Printing publication of cadre's guideline o	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. 10.000 books have been printed and have been distributed to the following provinces : a. West Java: 3000 books b. Banten: 1400 books c. South Sulawesi: 4300 books d. Papua: 500 books e. West Papua: 800 books

1.3.3. Printing of Essential Neonatal Health Care	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. 11,000 copies were distributed to 5 (five) GAVI provinces (Papua: 600 booklets, West Papua: 800 booklets, South Sulawesi: 4600 booklets, Banten: 1,500 booklets, and West Java: 3500 booklets).
1.3.4. IEC (Information, Education, Communication)	One of the attempts performed in terms of giving information and education to contribute support in the implementation of the child health care program and effective immunization as the effort to accelerate the reducing of AKB (Infant Mortality Rate) was through IEC media (e.g. leaflet and poster) with local content so as to make easy to understand and comprehend by the local community. 6172 posters and 31250 brochures have been produced and distributed to: 1) Papua Province 3086 posters and 15625 brochures; and 2) West Papua Province 3086 posters and 15625 brochures.
1.3.5. Printing publication of GAVI HSS IEC (Infor	This edition of GAVI HSS information handbook was expected to to give information related to GAVI HSS and activities performed started from year 2008 up through 2013, and to find out how big was the impact of GAVI HSS aid against the improvement of immunization coverage especially the one conducted by Mother and Child Health Program. So that every activity performed from the first GAVI HSS established, can be ascertained from the information within the GAVI HSS handbook. As many as 300 books have printed and distributed to provinces and Central. Therefore, every one who wishes to know about GAVI HSS can obtain information from the handbook mentioned
1.4 Sensitization of community and religious leade	
Advocacy towards community leaders and religious l	Problems and challenges in introducing immunization program in Indonesia are not limited on access, disparity of coverage between areas, human resources, logistics, cold chain, and low support of cross sector towards the related programs. However, there has been a presence of groups that refuse any immunization activities because of Halal vaccine issue (substances of vaccine permitted by Islamic rules) as well as other negative issues as the impact of immunization. Therefore, there is a need of persuasive approach thorough advocacy and socialization to those groups and to wide community. These activities were done in district of Tanggerang, Serang, Tasikmalaya and Majalengka.
Advocacy of Maternal Child Health and immunization	Advocacy of MCH and immunization programs towards religious leaders were done in order to create colaboration and support from them. These activities were done in the district of Serang, Bekasi, Jeneponto, Manokwari and Jayapura by including Islamic organization such as MUI, PP Aisyiyah, Church unity of PGI, and PKK
Objective 2 : Management capacity of MCH personnel	
2.1 Needs assessment by MoH/ PHO/ DHO staff of MCH	
1. Meeting of GAVI tranche-2 (2012-2014) Planning	One of GAVI HSS activities in year 2010 was Data Assessment in GAVI HSS 5 provinces (West Java, Banten, South Sulawesi, Papuan, and West Papua). This Assessment Data was meant as the referral data base in composing budget. The meeting Planning of GAVI Second Flow was the follow up action in planning and compiling the activity detail and Cost Budget of GAVI HSS Second Flow for year 2012. With this meeting of Activity Plan Drafting, it was expected the activity planning can be integratedly composed, without any overlapping, reciprocally complemented to support the target achievement. The objective of this activity was to compile the activity plan and cost budget of GAVI HSS for year 2012 through fund that already channeled so that can become the referral for activity and budget within the activity implementation in year 2012. This activity has been performed within 5 provinces of GAVI HSS.

Meeting Drafting of POA (Plan of Action) / RKA-KL	The development of POA /RKAKL GAVI HSS was done in 2012, which was very crucial to best determine timeframe of budgeting and disbursement of fund. All GAVI activities must be enlisted in the the DIPA (State budget document) through RKAKL, based on the regulation of the Minister of Finance regarding the management of donor fund, that states that all donor must be enlisted in DIPA. The process of entry into DIPA is the indeed the development of RKAKL.
Coordination Meeting to Implementation Activity GA	Some issues regarding the implementation of trance 1 GAVI programs were lack of program commitment. This affected the quality of program implementations in central, provincial, and district/city level. The trance 2 was disbursed in April 2012 which was expetected to be utilized according to the developed the operational guidelines at central and provincial level. After the development of operational guidelines, coordinate meeting was done to accelerate the implementations (reprogramming) in order to have a more focused activities and not just merely a supplemental of regular activities.
2.2 Advocacy by MoH/POH staff to district administ	
Province advocacy meeting with Related Cross Secto	These activities were carried out to put more synergy of immunization and MCH programs at the related cross sector in order to achieve the target of lower rate mortality, sickness, and paralised due to vaccine injection. These activities were carried out in both provinces, participated by the HC directors of MCH and immunization, immunization and MCH program executors, surveillance, Family Wellfare Movement, Education Office, and Regional Development Planning Bureau. The result was commitment of fund for immunization and MCH by from the Regional Budget, more integrated services of immunizatioin and MCH in order to achieve MDGs, Moreover, the Family Wellfare Movement is committed to optimize the role of cadres to more advocate community over the immunization.
Mentoring LP/LS (Government/Private Institution) A	Cross program/cross sector mentoring, by involving the experts in each areas of immunization/MCH, religious, as well as the immunization/MCH executors, in form of advocacy to stakeholders (head of district, Secretary of district, Head of Regional Development and Planning Bureau, Head HO. The activity was done in the province of Banten, Papua, South Sulawesi and West Java.
2.3 Development and distribution of management gui	
Penggadaan Tools Supervisi Monitoring & Bimtek	
2.4 Plan, design and conduct training of district	
Orientation of IMCI (Integrated Management Chilren	The activity of chart book orientation for nurse, midwife, and medical doctor, and hospital was a very important activity to provide the unskilled worker to perform health care for sick children under-5 and neonatal visit by using MTBM (Integrated Management for Newborn Baby). By applying IMCI (Integrated Management for Children Illness) and MTBM (Integrated Management for Newborn Baby), it was expected to be able to find children under-5 who have not got immunization accordingly to their age and to lessen the missed opportunity. The orientation for hospital was also mentioned to give comprehension for further referral, so that the hospital staff (in child section) will know between the IMCI management in public health center level and the hospital handling which is on diagnose basis. As for the activity detail, since the direct executor was from MCH Health Office of South Sulawesi Province, and the Sub-Directorate of Children Under-5 Life Continuance was merely requested to be the resource person, therefore we would need GAVI Central to coordinate with GAVI South
The meeting to Compile IEC Media Material for neon	The improvement of the material with this Local Content is required as the tools of information and education to give support in the implementation of child health care program and effective immunization as an attempt to accelerate the achievement of MDG-4 target. This meeting produced the draft of IEC material (as in brochure and poster) about the neonatal care including the immunization and alarm signs on neonatal as the test-run material in Papua.

The meeting to Compile IEC Media Material for neon	The purpose of the test-run was to find out how far the arranged IEC media can be understood and apprehended by the local community. This activity produced IEC material (as in brochure and poster) about the neonatal care including the immunization and alarm signs on neonatal as the tool to widespread important information for the community in terms of child health care program and.
2.5 The health centre team training in micro plann	
HC Management Training for district HC staff	The implementation of the activity by applying management functions starting from data analysis, planning, implementation, and evaluation must be performed in order to achieve the organization's objective; therefore the staff of Public Health Center and District/City must comply to HC Management Training. After the training is accomplished, this trained HC staff is expected to make planning and evaluation of HC manpower by applying the management functions. Until 2011 there were 501 HCs that have complied to HC Management. Statistic: a. West Java: 600 staff from 20 HCs b. Banten: 108 staff from 36 HCs c. South Sulawesi: 180 staff from 60 HCs d. Papua Province : 27 HCs e. West Papua : 10 HCs
Objective 3: Partnership formed with non-governmen	
3.1 Identification of partners, development of act	
Evaluation for Sector Partners in MCH Service Deli	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.
3.2: Strengthening coordination, implementation of	
Technical Orientation on MCH Regulation Janpersal	This activity very much supports "Birthing Assurance" 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 MoU of "Birthing Assurance".Apart from the targeted individuals, there were other persons who attended this orientation meeting because of its importance.The achievements in 1 provinces are described as follows:West Papua province: 5 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 facilityd. 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

Technical Orientation on Midwifes - TBA's Partners	These meetings were conducted in District and were attended by District health officers, Health Center and village/ community midwives. These meetings are as continuations staff of Orientation community midwives and TBA's These meeting have similarity with orientation on providing midwife- TBA partnership at central level that has been attended by representative of the meeting's GAVI HSS province and district. The Objectives are: 1. To increase 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-solving 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.
Orientation on Providing Midwifes - TBA Partnershi	This meeting was conducted at central, provincial and district Health Office level. 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 servicesThis meeting will be continued in the similar meeting at provincial level. The 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 identified: 1. There were midwives and TBA who did not yet want to collaborate with each other to help delivery 2. TBA still needed several times to be able collaborate with midwives. 3. Many TBAs live in the difficult to reach villages 4. There were midwives who were still not able to perform delivery Results of the meeting: 1. Increased knowledge of partnership 2. Increased cases of midwife – TBA partnership 3. Drafting of MOU 4. Development of problem solving on partnership and improve guidance and monitoring.

Reguler Meeting CSOs group for Community mobilizat	This reguler meeting was implemented at district level and was attended by participants from District Health Office and CSO's. Basically this meeting was to monitor the progress of CSO partnership in order to increase the coverage of MCH and Immunization services. Th meeting's objectives: 1. To identify the progress of partnership activities carried out 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: 1) West Java 100 persons. 2) Banten: 140 persons.Tangerang City did not conduct the activity because its local policy requires all supporting budget from out side district had to be separated from its district financial management.The CSO's, for example : 3) South Sulawesi : 400 persons 4) Papua : 33 persons In general the problems was : 1) The MOU did not yet develop 2) CSO budget limitations 3) CSO's activities reporting
Reguler Meeting Community Midwives and TBAs in Vil	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 immunizations 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 participated in this activity were: West papua :Technical orientation that was conducted at district/city level and was attended by MCH, immunization and other related program executors from District Health Office ond health center staff, including Head of HC, HC's Midwives, village/ community midwives.Basically this orientation was to explain the consept of village/ community and TBAs partnership, activities, how to develop partnership. The objectives: 1. To explain the concept of midwives and TBAs partnership due to increase the coverage of MCH and immunizations 2. To inform the stages of building partnership, for 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 were: 1. Increased understanding of midwives and TBA partnership concept, stages of activities that conform to the increased MCH and immunization services 2. Participants haved agreed to follow up the result of meeting, such as MOU development, etc
3.3: Engaging private sector partners in MCH servi	
Evaluation for sector partners in MCH service deli	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.
Reprogramming	
Objective 1 : Area with low immunization coverage	
Develop and distribute IEC material and social mob	

1. The development of media of Commmuicatin, infor	The improvement of the material with this Local Content is very required as the tools of information and education to support the implementation of child health care program and effective immunization as an attempt to accelerate the achievement of MDG-4 target. The arranged IEC Media previously for the provinces of Papua and West Papua can only be utilized for coastal area, while for mountains and isolated area the information should be using more pictures. This meeting produced a draft IEC material (as in brochure and poster) about neonatal care, the alarm signs on neonatal, and immunization as the test-run material in mountains and isolated area in the provinces of Papua and West Papua The pilot project was done at the remote district of Monokwari of West Papua Province as well as Jayawijaya district and Jayapura district of Papua province. The result was used as points of discussion at finalization meeting in Makassar city. The output was The development of media of Commmuicatin, information and Education on Neonatal and Imunization, such as posters about neonata information as well as the easy to understand advantage of immunization for the community in those remote areas of papua and west papua.
2. Procurement and distribution of MCH books for I	An effort to increase knowledge of cadres, Religius officials, and other Islamic organizations about the importance of immunization and maternal and child health, which need to be harmonized between provincial and district local knowledge. Banten province which is mostly Muslim and requires an understanding of relevant Immunization and Maternal and Child Health in which the material is sourced from the Qur'an as scripture. This activity is carried out in the province of Banten and will be distributed to the districts. This activity begins with the first meetings to make MCH handbook revisions based on Al-Hadist/Al-Quran sources. This handbook is still in process of revision and will be printed in the center as much as 3,500 books. The purpose of this activity is also to obtain support from other Islamic organizations in Immunization and Maternal and Child Health services. In a book which will be in print, contains lots of messages of Immunisation and MCH programs in islamic verses which supporting Immunisation and MCH. Muslim organizations are expected to disseminate these messages into their groups that refuse immunization and also to other people.
Printing & Distribution of Handbook of Child Healt	
1. Modul Book	The activity of improving the cadre’s capacity on infant health in the attempt to improve the coverage of immunization needs implementation guideline and standardized curricula to maintain the outcome of the arranged training. This activity has not performed while still wait for the final module editing
Sozialisation and advocacy between cross sectors t	
2. Coordinative and advocacy meeting between cross	Coordinative meetings and socialization for the 13 provinces and 58 district / city that adopt IRI programs.This meeting was held on 7-9 November 2012 in Bogor. The purpose of this activity is to promote and coordinate the activities of GAVI Reprogrammings in the provinces and districts/cities that will be used for the reinforcement and improvement of routine immunization, so that UCI performance at the village in 2014 could reach 100%. Participants came from 13 provinces and 58 districts / cities that adopt IRI programs (22 districts / cities of HSS and 36 districts / cities of IRI). It was initially planned that 58 districts / cities would participate, but in actual there were only 48 districts / cities, as the East Java province’s district / city which adopt IRI were doing diphtheria immunization at the same time. The result of this activity is the commitment of districts / cities to carry out activities in accordance with the specified targets of GAVI HSS Reprogramming, namely advocacy and coordination with cross-sector and cross-linked programs, implementation and training for officers of DOFU (Drop out Follow Up) immunization at hospital.

3. Routine immunization through DOFU at 58 distric	This activity is aimed infants aged 0-11 months who have not received a complete primary immunization. The goal was to improve immunization coverage of DPT-HB3. The result in 2012 was the increased coverage of DPT-HB3 (100%) compared to that of 2010 (94.9%) and in 2011 (94.9%). In 2013, this activity is continued to aim infants who have not been immunized in 2012. 11 IRI districts that did not carry out coordinative meetings at the district level while carrying out DOFU in 2012, conducted a preliminary coordinative meeting attended by representatives of the head of health centers, immunization coordinator, midwife coordinator, health centers and MCH coordinator.
4. Media campaign on Immunization	This campaign on immunization was carried out in 2 stages. Phase 1 was conducted in November-December 2012, and the 2nd stage was done in March 2013. The campaigns were aired on 2 private TV stations (MNC TV and Trans 7), one national television station (TVRI) and on airport TV with a duration of 30 seconds.This activity aims to increase awareness and knowledge of the public, especially on mothers, about the importance of immunization to infants. It is necessary to promote and support the delivery of immunization as the primary intervention to improve child health, one of which is the provision of access to the right information about the infant immunization schedule in a sustainable manner. The campaign is also expected to mobilize all stakeholders to provide support for the implementation of immunization.
5. National Media workshop to sensitize 44 journal	This activity was participated by journalist from 22 IRI provinces, aimed at obtaining media support to increasing knowledge and awareness of immunizationand in turn increase public demand. This activity resulted in the commun understanding between journalists about immunization, who then immediately follow it up by publishing news about immunization in each of their respective area, as well as a commitment of the reporters to make regular writing / news on the media each week, especially in event of World Immunization Week that was held on 22 to 27 April 2013.
Objective 2 : Capacity Development on ensuring dat	
Revise and standardize tool for reporting and reco	
Refreshing training and implementation of DQS at t	Data Quality Self assessment and (DQS) in the form of training has been implemented in 58 districts / cities, consisting of 24 districts / cities in three HSS provinces and 34 IRI's districts / cities. This activity was conducted in January-April, 2013, with the training for staff of immunization in 58 districts / cities. The methods used are lectures, question and answer and field practice. Implementing the evaluation phase was followed by DQS in 58 districts / cities in each sample at least in 2 health centers for each district / city. This activity compares the data at each level, starting from the village to provincial level cohort. From the results of the implementation of DQS, it appears that the accuracy of the data from the village to the health center is still low, while at the health center level to district / municipal and district / city to the provinces are far more accurate. In the assessment of the quality of the results, only 60% was according to the standard.
Objective 3 : Improve immunization staff competenc	

Review & revise the immunization and MCH component	Midwives provide continuous service and comprehensive, focusing on aspects of obstetric care, prevention, and promotion, building partnerships and community empowerment with other health workers to provide quality services based on community needs. In order to ensure those services, there is required standard of profession as a reference to do all acts and care provided in all aspects of service to individuals, families and communities, on the input, process and output (decree of the Minister of Health no. 369/MENKES/SK/III/2007). Independent Midwives Practice is one of the main providers of primary health care services that is the foundation of improved maternal and child health. Therefore, midwives are required to be competent in providing midwifery services. Competent midwife is the result of experience and midwifery education process. Thus, the competence of midwife is determined by their midwifery educations, of which one them is the curriculum on midwifery skills that can provide midwifery services to the community, particularly focusing on the achievement of the optimal health status of mothers and children. Thus, it is necessary to see a clear picture of factors that support the capabilities and competence of midwives in providing services to the community, particularly from the midwife providers (midwifery education institutions). Based on the that picture, appropriate interventions to improve the capability and competence of midwives can be taken. The purpose of this activity: 1. Obtaining an overview of the knowledge of midwifery students on matters related to essential maternal and child health and immunization. 2. Obtaining an overview of learning processes encountered at the level of midwifery education institutions. 3. Obtaining an overview of technical problems faced by midwives in their real health duties. The activities that are being done: 1. Initial consolidation study 2. preparation of Instruments 3. Instrument trials 4. instrument repair 5. the necessary permits 6. Training of Data Collectors 7. Data collection at the Institute of Education Midwives and Health Care Facilities The prorgress of ongoing activities until the third week of May 2013 1. Data processing 2. Reporting Dissemination of the results of the activities will be held the fourth week of May 2013. The results of this study are expected to contribute to illustrate the problems of midwives ability and competence, which in turn, is expected to focus on strengthening interventions in evidence-based policy in improving the capability and competence of midwives (evidence based policy) in providing midwifery services that focus immunization and health mother and child.
District level technical orientation and sensitizt	

1. Technical orientation to improve immunization c	The midwife and TBA partnership has long been performed, yet in practice, this is still far from the expectation since there is no any concrete form of agreement between them; therefore midwifes and TBAs still perform delivery process separately, making MCH services as well as delivery services are not as expected. The objective of this activity is to evaluate the conducted partnership forms within respective district/city and to assess the effectiveness of the partnership result performed, also to discover the problem and obstacle in the partnership implementation and seek problem/obstacle solving. This activity was conducted in form of meeting in district/city with methods of speech, Q and A session, interactive discussion, and group assignment and simulation suitable with the needs which was facilitated by resource person from distrct/city Activity outcomes: - It has been formulated several agreements in village level which will be used as referral in motivating the targets to improve the immunization coverage within the respective village - The head of Public Health Center is ready to facilitate the partnership between TBA and village midwife in order to improve the immunization coverage
District level comprehensive training of the healt	
1. Comprehensive MCH and immunization management	The process of carrying out this training of integrated management was conducted in 5 days with the facilitator provided material presentation and simulation with visual aid which the basic material consists of basic policy of public health center and build work group; the essential material consists of integration of MCH program and immunization within Public Health Center management, planning, mini workshop, performance appraisal, and other supporting material consisting RTL (Follow Up Plan) and BLC (Building Learning Commitment). Activity outcomes: - Forming of working group in the public health center. - Planning of annual activity in public health center especially in sector of MCH and immunization - Analysis for every outcome of MCH program and immunization. - Forming of consensus i.e.: socialization on the outcomes of public health center management training to all staff; drafting vision and mission of public health center; data collection upon evaluation of activity outcomes for 1 year; improvement of performance after working group formed; forming working group in order to compose RUK (Activity Proposal Plan) and evaluation; conducting the first monthly mini workshop to compile RUK (Activity Proposal Plan), RPK (Activity Implementation Plan), and POA (Plan of Action) year 2013; improvement of program integration in attempt to improve public health center performance; monthly report received by Health Office at the 5th of next month at the latest; also agreed the color for year 2013 for PWS (Local Area Monitoring) graphic.. Activity follow up: - Socialization upon the result of public health center management training - Forming an integrated management working group - Compiling RUK (Activity Proposal Plan), RPK (Activity Implementation Plan), and POA (Plan of Action) for year 2013 - Implementing the activity of MCH and immunization integrated management - valuation on each program Local Outcomes : - West Java: Have 110 public health centers trained in 11 districts/cities. - South Sulawesi: 236 public health centers trained in 15 districts/cities - West Papua : not implemented yet

2. TOT of HC management to improve MCH and immuniz	In order to optimally deveop health services, public health center is obliged to perform a good management. Public health center management is a series of activity performed systematically to produce public health center outcome by means of effective and efficient. Public health center management consists of (P1) Planning, (P2) Mini Workshop, (P3) Public Health Center Performance Appraisal. The entire activities above were one unit reciprocally related and continuous. As for the objective of this activity is the participants were expected to be able to become the trainer in the Public Health Center Management Training in terms of Improvement of MCH and Immunization Coverage. Activity outcomes: - Participant listed as facilitator of public health center management in respective district/city - Participant socialized the training outcomes to the entire cross-sectoral program within Health Office of respective district/city - Participant followed up the training outcomes by having coordination with related cross-sectoral program by conducting technical guidance of public health center management within Public Health Center - Participant followed up the training outcomes by conducting RTL (Follow Up Plan). Activity follow up: District/city implemented the integrated management training of MCH and Immunization in public health center with funding resource both from GAVI HSS and APBD (Local Expense and Income Budget).
District level comprehensive training of the healt	
1. Immunization Management training for hospital w	Immunization Management training for hospital was conducted in 3 provinces: Banten, West Java and South Sulawesi, attended by hospital personnel who carry out immunization services. The target hospitals were the government hospital, private hospital private, military hospitals, and state owned hospital that are located in thise 3 provinces. To improve immunization coverage and good range of recording and reporting system, there must be a data of immunization status of all infants, regardless where they got the immunization. From 305 hospitals that are targeted to be trained, in 2012 only reached 64 RS, while the remaining 241 RS has been carried out in January-April 2013.
2. District level comprehensive training of the he	Training was done at 103 districts/cities' of 1504 HCs in the provinces of Riau, Kepri, Bengkulu, West Sumatra, South kalimantan, Central Kalimantan, West Kalimantan, and East Kalimantan. This training was carried out by TOT method, targeting immunization program executors, district/city health posts, as well as HCs, involving Training Centres (Bapelkes) in order to ensure a standardized training process. The purpose of this activity is to enhance the ability of clinic staff in managing immunization and MCH activities in an integrated manner. In 2012, 86 health centers in 19 districts/cities the provinces of Bengkulu and Riau Islands province have carried out the training, while 1,418 health centers in 84 districts / cities of the Provinces of Riau, Sumatra and Kalimantan, have carried it out in January-April of 2013.
District level training of cadres on basic immuniz	

1. Cadres Training	Community participant is very much needed in attempt to improve the immunization and MCH coverage, and in order to motivate the community there should be trained MCH Care Center Cadre. Health cadres in the village/MCH care center are volunteers who can facilitate access for community and health worker to obtain health services. In practice, cadre gives elucidation, also acts as an activator and motivator for childbearing mothers and mothers with babies; therefore it is necessary to equip and to increase the cadre's concept in infant health care. The objective of this activity is to escalate the cadre's capacity concerning baby's health in attempt to improve immunization coverage. Activity outcomes: - Improving cadre's capacity - Cadre can give information concerning child health to the community correctly - Cadre can have early detect on mother and child - Escalating the community empowerment so that the immunization improved - Can detect any malnutrition early. Follow up: All participants of cadre's training to continuously work together in attempt to improve the community empowerment within respective areas, so that they can become the health vanguard and able to bridge existing problems in their areas with health workers Input indicators : - West Java: 4800 trained cadres within 12 district/city - South Sulawesi: 9208 trained cadres within 13 district/city. - Banten : 368 trained cadres within 4 district/city.
2. The development of curriculum for cadres of chi	The activity of improving cadre's capacity concerning neonatal health in attempt to improve the immunization coverage needs implementation guideline and standardized curricular to maintain the outcomes of the arranged training This activity produced curricular module for training of child health cadres.

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

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?

In line to strengthen the policy and guideline for midwifes, the IBI (Midwifes association of Indonesia) were involved and orientated.

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 2011 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	2012 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2008	2009	2010	2011	2012		
(Before Reprogramming) Objective. 1.Community mobilized to support MCH											

Percentage of community health workers (cadres) in target sub districts trained in community mobilization	N/A	N/A	80%	52%	N/A	N/A	16,46 %	29.22 %	47,75 %	DHO	-Achievement of the target was calculation from the HSS and CSO activities -Target was not achieved due to lack of funds for training of cadres
(Before Reprogramming) Objective 2. Management capacity of MCH personel improved											
Percentage of the target sub district with staff trained in management	N/A	N/A	100%	66%	N/A	N/A	20,46 %	24%	68%	DHO	Up to 2012, total of HC with staff trained were 992.. The percentage of target achieved was 68%
Percentage of the sub-districts regulary following good management practices after training	N/A	N/A	80%	59%	N/A	N/A	20,46 %	24%	68%	DHO	Up to 2012, total of HC following good management after training were 992. The percentage of target achieved was 68%
(Before Reprogramming) Objective 3 Partnership formed with non-goverment provincies											
Percentage of the target districts having joint regular meeting with CSO's	N/A	N/A	100%	64%	N/A	N/A	38,37 %	58%	64%	DHO	-Achievement of the target was calculation from the HSS and CSO activities
(After Reprogramming) Area with low immunization coverage through acceleration of immunization coverage in low coverage areas*											
1. Numbers of low immunization coverage districts/cities that achieve coverage of DPT-HB ≥ 80%	103 out of 497	100%	100%	56% or 58 Districts	N/A	N/A	N/A	N/A	56%	Report of routine immunization	58 Districts has been achieve coverage more than 80%
(After Reprogramming) Capacity Development on ensuring data collection and reporting											
1. Percentage of districts/cities that conducted the DQS	0	0%	80%	N/A	N/A	N/A	N/A	N/A	0	Annual report of DQS from Immunization Sub Directorate	This year, just start conduct TOT for 58 district trainers.

(After Reprogramming) Improve immunization staff competency through strengthening implementation of MCH-Immunization material for midwife institution											
1. Percentage of institutional midwifery and nursing schools are using teaching modules immunization	N/A	N/A	51 (100%) institutional	N/A	N/A	N/A	N/A	N/A	0	Percentage of institutional midwifery and nursing schools are using teaching modules immunization	because still within progress then it for achievements this activity will be able measured at the end the year 2014

9.4. Programme implementation in 2012

9.4.1. Please provide a narrative on major accomplishments in 2012, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

Original Activities (before reprogramming) :

1. 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.

1.1 Assessment and mapping of existing situation relating to community activities in the selected provinces

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.depkes.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 utilization of findings for advocacy to local government, political leaders is still undergo. For detail clarification on assessment, describe on table 9.2.1

Considering the vast number of conducted Village Mapping (VM) and Service Availability Mapping (SAM) data surveys, it is necessary make use of those data optimally, one of which is through workshops at each of GAVI HSS Provinces This is particularly useful to scoop up problems and finding solutions based on those survey data as well as from other related data which are available at GAVI HSS districts/cities. From there, new evedance – based policy may be created.

Generally, the objective of workshop is to utilize the survey data of the 2010 GAVI – HSS as well as other data, in order to determine priority of problems at district/city level. The objective of the workshop in particular as follows:

a. Make inventory of problems of MCH

b. Set up priorities of MCH, including immunization coverage at district/city level, based on 2010 GAVI – HSS survey data

c. Set up alternative solution of the determined problems

d. Set up priority of problems based on 2010 GAVI – HSS survey data anlisys.

e. Set up phase 2 GAVI – HSS according to the determined priority of problems

The data used in this workshop include: targeted pregnant and partum cases, and babies. The type of data to be created is absolute data and percentage of 4th visit, partum, 1st neonatal visit, complete neonatal visit,
HB0, BCG, Polio 4, DPT3, and measles.

From the result of overall data, the problems can be identified (
focusing on each HC), by identifying the first, the second, the third problems, etc. to be then drawn the root of problems, which from there the the scale of priority is made. This scale of priority will determine any solution to be decided at each HC, to put into consideration the availability of resources at each HC.

Results from 5 provinces:

Workshop was carried out by the coordinator of GAVI HSS at provincial level, including team of the Min. of Health as well as the team of university that manages GAVI HSS programs. The results are as follows:

- Workshop at West Java province, involving provincial level GAVI executors as well as 26 districts/cities level that were the coverage areas of VM and SAM of Gavi HSS. From this workshop, it is expected that there will be budget for immunization advocacy, better skill of HC director and immunization coordinators, recommendation on staffing management based on work load, empowering the community, better coordination of cross sector performance regarding recording and reporting, make analysis of work load particularly on midwife, and the skill of program executor in analyzing problems as a base of making program budget.

- Workshop at Banten province by involving provincial level GAVI executors and 8 districts/cities that were the coverage area of VM dan SAM

- Workshop at South Sulawesi by involving provincial level GAVI executors and 12 districts/cities that were the coverage area of VM dan SAM.

- Workshop at Papua province by involving provincial level GAVI executors and 3 districts/cities that were the coverage area of VM dan SAM.

- Workshop at West Papua province by involving provincial level GAVI executors and 2 districts/cities that were the coverage area of VM dan SAM.

For West Papua province, there is still lack of facilities at HCs, particularly in remote areas, lack of staff of immunization and MCH, lack of skill, insufficient standard of costs agreed and those available on the field. Therefore, the solution proposed is to add more facilities, more staffing, better skill particularly on immunization and MCH, adjustment of standard of costs that are enough to apply on the field.

1.2 Increase the knowledge of cadres on infant health as well as type and schedule of immunization

Role of cadre in improving the community participant t improve the coverage of Immunization and MCH is very strategic and their knowledge need to be escalated through training or orientation.
Health cadres in the village/MCH care center are volunteers who can facilitate access for community and health worker to obtain health services. In practice, cadre gives elucidation, also acts as an activator and motivator for childbearing mothers and mothers with babies; therefore it is necessary to equip and to increase the cadre's concept in infant health care. Therefore this activity is very important to be performed. The objective of this activity is the escalation of knowledge and skill of cadres and public figures in mentoring and empowering the community to improve the coverage of immunization and MCH program, and eventually expected the skilled cadre of MCH care center able to apprehend about mother's health care post birthing, neonatal health care, helping health worker in preparing target of MCH and immunization; and also ca

dres able to give socialization regarding their applied training to other cadres in respective areas

1.3 Development, procurement and distribution of IEC materials and equipment including Buku KIA (MCH handbook)

The activities are:

1. To distribute IMCI Chart books in 5 Provinces :

· Central : 460 books

· West Java : 3.450 books

· Banten : 995 Books

· South Sulawesi : 1.065 Books

· Papua : 170 Books

· West Papua : 110 Books

2. To distribute Child Health Books for cadres in 5 Provinces:

· West Java : 3.000 Books

· Banten : 1.400 Books

· South Sulawesi : 4.300 Books

· Papua : 500 Books

· West Papua : 800 Books

3. To distribute Essential Neonatal Health Services Handbooks in 5 provinces:

· West Java : 3.500 Books

· Banten : 1.500 Books

· South Sulawesi : 4.600 Books

· Papua : 600 Books

· West Papua : 800 Books

4. EIC Media (Leaflet, Posters about neonatal health status with local content to be distributed in 5 provinces

6,172 posters dan 3,1250 brochurs have been produced and distributed to :

· Papua : 3086 Posters dan 15625 brochures

· West Papua : 3086 Posters dan 15625 brocuhers

5.
Printing publication of GAVI HSS IEC (Information, Education, Communication) materials (HSS information handbooks)

This edition of GAVI HSS information handbook was expected to give information related to GAVI HSS and activities performed started from year 2008 up through 2013, and to find out how big was the impact of GAVI HSS aid against the improvement of immunization coverage especially the one conducted by Mother and Child Health Program. So that every activity performed from the first GAVI HSS established, can be ascertained from the information within the GAVI HSS handbook.

300 books have been distributed to provinces and Central so that information about GAVI HSS can be obtained from that handbook.

1.4 Sensitivity of community and religious leaders towards MCH issues, including immunization and the role of cadres.

A.
Advocacy towards TOMA (Community Figures) / TOGA (Religious Figures) against immunization refusal in Banten Province and West Java Province

Problems and challenges in introducing immunization program in Indonesia are not limited on access, disparity of covera ge between areas, human resources, logistics, cold chain, and low support of cross sector towards the related programs. However, there has been a presence of groups that refuse any immunization activities because of Halal vaccine issue (su bstances of vaccine permitted by Islamic rules) as well as other negative issues as the impact of immunization. Therefore , there is a need of persuasive approach thorough advocacy and socialization to those groups and to wide community. Th ese activities were done in district of Tanggerang, Serang, Tasikmalaya and Majalengka
, attended by the local administrative leaders, local ulema leaders, community leaders, local Health Office, and anti immu nization groups. Through this meeting, the commitment was created from the local government to support immunization s ervices and for the community to have accurate information about immunization, for a better coverage

B. Advocacy of Maternal Child Health and immunization program to religious organizations in 5 provinces

Advocacy of MCH and immunization programs towards religious leaders were done in order to create collaboration and s upport from them. These activities were done in the district of Serang, Bekasi, Jeneponto, Manokwari and Jayapura
which included Islamic organization such as MUI, PP Aisyiyah, Church unity of PGI, and PKK
. The results of the meetings in those provinces were commitments by the organizations involved to dessiminate accurate information about immunization programs, so that there will be a heightened demand from the community towards immu nization.

Objective 2 (Improved management capacity of MCH staff)

2.1. Needs assessment by MoH/ PHO/ DHO staff of MCH management issues at district and health centre level

Establishment of GAVI HSS planning document in 2012 with more emphasis immunization program through HSS progra m, preparing TOR activity and to select some indicators of MCH and Immunization program. The proposal of the manage ment program is that the MCH programs aim to oversee the status of health of both mother and child, such as assistance on pregnancy cases and not to significantly targeting the immunization program in short term. Rather, MCH program acti vities are investments in maternal health care and children (the medium / long term). This activity was conducted in
5 provinces.

2.2 Advocacy by MoH/POH staff to district administration and political leaders for adequate budgedtary support of MCH a ctivities

Advocacy meeting with Provincial Traffic Related Sectors of the District / Municipal Strengthening Program for MCH
and Immunization (West Java and South Sulawesi). This activity aims to enhance the knowledge of MCH
and Immunization program managers in order to reduce mortality, and paralised due to vaccine injection.

2.3 Development and distribution of management guidelines, tools (such as supervision)

Printing of supervision, monitoring and technical guidance tools.

This book is for guidance for gavi hss personal from central until district level to monitor the activities. This tool is use full t o assists developing APR.

2.4 Plan, design and conduct training of district Training Team who will give training at HC level

A.
Orientation of IMCI (Integrated Management Children Illness) Chart Book in attempt to improve the immunization cov erage in South Sulawesi Province

The activity of chart book orientation for nurse, midwife, and medical doctor, and hospital was a very important activity to provide the unskilled worker to perform health care for sick children under-
5 and neonatal visit by using MTBM (Integrated Management for Newborn). By applying
of IMCI (Integrated Management Children Illness)
and MTBM (Integrated Management for Newborn Baby), it was expected to be able to find children under-
5 who have not got immunization accordingly at their age and to lessen missed opportunity. The orientation for hospital w as also to give comprehension for further referral, so that the hospital staff (in child section) will know between the IMCI management in public health center level and the hospital handling which is on diagnose basis

B.
The meeting for Compiling IEC Media Material for neonatal health and immunization with local content for Papua and West Papua area

The improvement of the material with this Local Content is very required as the tools of information and education to give support in the implementation of child health care program and effective immunization as an attempt to accelerate the ac hievement of MDG-4 target.

C. Test-run of Leaflet and Poster with Local Area Content in Papua

The purpose of the test-
run was to find out how far the arranged IEC media can be understood and apprehended by the local community. This ac tivity produced IEC material (as in brochures and posters) about the neonatal care including the immunization and alarm signs on neonatal as the tool to widespread important information for the community in terms of child health care program and immunization.

2.5. The health centre team training in micro planning, supervision, M&E, surveillance and managing community develop ment

Increasing the quality of mini workshop activities at the health center as a media to develop micro-
plan for next month activities will increase the performance of PHC services. The trained health center manager will ensu re the quality of mini workshop activities. Training Modules on health center management are needed for review so that t he implementation can be more easily understood and meet with the real conditions in the health centers. However, seve ral facilitators who had been trained were not ready to train or be resigned for other duties, so the ToT in some places sh ould be repeated.

Until 2012 there were 992 health centers have been trained on management of health centers.

Objective 3 (Partnership formed with non-government agencies)

3.1 Identification of partners, development of action plan, formulation of MOUs.

The purpose of this activity is to improve knowledge and skills of health center staff. They are expected to be able to kno w how to examine, classify the symptom of illness, and treatment so they will have confidence to immunize the baby due to clear classification of illness. They also have to check the status of immunization, as this will contribute to the increase of the immunization coverage and to avoid missed opportunity. The activity was started by a training of trainer at provinci al level, who later on will be assigned to train district health staff, who then will train health center staff to be able to work i n the community.

3.2
Strengthening coordination, implementation of MOU, including regular consultations and joint monitoring and evaluation

Increasing coverage results local monitoring of MCH, immunization and birthing through “Birthing Assurance”

Increased deliveries by health workers and in partnership with the TBA with reference to the MOU agreed upon and clarif y the division of tasks midwives and herbalists and involve volunteers in the implementation of its activities. Need strengt hening and support from the village level, district, district and provincial

Increased collaboration with CSO's especially mother and child health activities, integrate and synergize with chaperone CCT officials at districts and villages
The existence of support from community leaders and religious leaders in coaching and helping TBAs to understand the i mportance of labor process within “Birthing Assurance”.

1. Regular Meeting of CSOs for Community mobilization and service delivery efforts (at Jayapura City and Biak Numfor) and Banten

Increasing immunization coverage through the support of the private sector in the form of partnerships. Papua
Provincial Health Office to prepare CSOs in common formats of cooperation with the Government
in the province of Papua

3.3: Engaging private sector partners in MCH service delivery, including orientation to government policies on MCH, and sensitization of TBAs and private midwives

The objective of the activity is to evaluate the progress of partnership activity in provincial and district level. The activity w as planned to be conducted at central level, followed by PHO and DHO staff. HASIL???

Activities under reprogramming

1.
Objective 1 : Area with low immunization coverage through acceleration of immunization coverage in low coverage ar eas*

The following detail activities will be implemented through reprogramming;

Area specific implementation in the “low immunization coverage area” to reach the un-reached area and population:

· Identify Districts that do not meet the target of “UCI in village level” or with low coverage of “UCI in village level”

· From all the districts that do not meet the target of “UCI Village”, identify: the villages that meet UCI 2008-2010 target and those that not meet UCI 2008-2010 target.

· The activities to be implemented are as follows:

· For all areas within those selected districts the activities were as follows:

- “Integrated Health Centers Management” including utilization and improving “Mini workshop” and micro planning mechanism; using BOK funding mechanism to co share with the GAVI support fund.

- Integrated “Individual data registration system” with cohort system

- Implementation of DQS (Data Quality Self-assessment)

- Close supervision and mentoring

- Socialization and advocacy to the key stakeholders and decision makers

· For villages that do not reach the UCI during the period 2008-2010 will follow a special effort

· Quality supervision and mentoring

1. Development of IEC Media on Neonatal Health and Immunization with Local Content for mountain range and isolated area in Papua and West Papua is one of the attempts performed in terms of giving information and education to contribute support in the implementation of the child health care program and effective immunization as the effort to accelerate the reducing of AKB (Infant Mortality Rate) was through IEC media (e.g. leaflet and poster) with local content so as to make easy to understand and comprehend by the local community. 6,172 posters and 31,250 brochures have been produced and distributed to: 1) Papua Province 3,086 posters and 15,625 brochures; and 2) West Papua Province 3,086 posters and 15,625 brochures. With the IEC media that is easily understood by the local communities in the provinces of Papua and West Papua, this may improve the health care coverage of neonatals as well as immunization coverage in order to reduce IMR.

2. Coordinative meetings and socialization for the 13 provinces and 58 district / city that adopt IRI programs. This meeting was held on 7-9 November 2012 in Bogor. The purpose of this activity is to promote and coordinate the activities of GAVI Reprogrammings in the provinces and districts/cities that will be used for the reinforcement and improvement of routine immunization, so that UCI performance at the village in 2014 could reach 100%. Participants came from 13 provinces and 58 districts / cities that adopt IRI programs (22 districts / cities of HSS and 36 districts / cities of IRI). It was initially planned that 58 districts / cities would participate, but in actual there were only 48 districts / cities, as the East Java province’s district / city which adopt IRI were doing diphtheria immunization at the same time. The result of this activity is the commitment of districts / cities to carry out activities in accordance with the specified targets of GAVI HSS Reprogramming, namely advocacy and coordination with cross-sector and cross-linked programs, implementation and training for officers of DOFU (Drop out Follow Up) immunization at hospital.

3. Coordinative and Advocacy meeting at district / city level with the related cross sector/cross program for the Health Center. This meeting was to develop a strategy of action plans, strengthening networks, and to build commitment, in order to reach the targeted indicator (DPT-HB3). Participants consisted of representatives of heads of health centers, immunization coordinator, midwife coordinator, health centers, and MCH coordinator. This meeting resulted in a mutual commitment between the head of health centers, immunization coordinator, and various programs to help solve the problems that arise, especially to achieve immunization targets in each area. Activities were carried out in 47 districts / cities in 13 provinces.

4. Implementation of Routine Immunization through DOFU in 58 districts / cities of 13 provinces where low immunization coverage were identified.

This activity is aimed infants aged 0-11 months who have not received a complete primary immunization. The goal was to improve immunization coverage of DPT-HB3. The result in 2012 was the increased coverage of DPT-HB3 (100%) compared to that of 2010 (94.9%) and in 2011 (94.9%). In 2013, this activity is continued to aim infants who have not been immunized in 2012. 11 IRI districts that did not carry out coordinative meetings at the district level while carrying out DOFU in 2012, conducted a preliminary coordinative meeting attended by representatives of the head of health centers, immunization coordinator, midwife coordinator, health centers and MCH coordinator.

5. Media campaign on Immunization

This campaign on immunization was carried out in 2 stages. Phase 1 was conducted in November-December 2012, and the 2nd stage was done in March 2013. The campaigns were aired on 2 private TV stations (MNC TV and Trans 7), one national television station (TVRI) and on airport TV with a duration of 30 seconds.
This activity aims to increase awareness and knowledge of the public, especially on mothers, about the importance of immunization to infants. It is necessary to promote and support the delivery of immunization as the primary intervention to improve child health, one of which is the provision of access to the right information about the infant immunization schedule in a sustainable manner. The campaign is also expected to mobilize all stakeholders to provide support for the implementation of immunization.

6. National Media
workshop to sensitize 44 journalist from the 22 identified provinces (5 HSS Provinces, 10 IRI Provinces and 7 provinces in Sumatera that not include as IRI provinces) ensure public awareness and complient. The workshop to be supported by media campaign in these provinces/districts.

This activity was participated by journalist from 22 IRI provinces, aimed at obtaining media support to increasing knowledge and awareness of immunizationand in turn increase public demand. This activity resulted in the commun understanding between journalists about immunization, who then immediately follow it up by publishing news about immunization in each of their respective area, as well as a commitment of the reporters to make regular writing / news on the media each week, especially in event of World Immunization Week that was held on 22 to 27 April 2013.

2. Objective 2 : Capacity Development on ensuring data collection and reporting

With the implementation of DQS at is expected to improve the quality of immunization data in the health centers that includes 22% of existing health centers. The increasing of capacity at district officials will provide them the opportunity to implement the DQS independently using local funds that will increase the reach of DQS implementation. The increasing scope of data quality in all levels will increase coverage in the community thereby reducing the immunization data gap between reports and coverage surveys.

A. Revise and standardize tool for reporting and recording individual resistrations (hard and soft) at health centre level (not yet carried out)

· Refreshing training and implementation of DQS in 3 HSS provinces (West Java, South Sulawesi and Banten) and 34 identified districts under IRI.

Data Quality Self assessment and (DQS) in the form of training has been implemented in 58 districts / cities, consisting of 24 districts / cities in three HSS provinces and 34 IRI's districts / cities. This activity was conducted in January-April, 2013, with the training for staff of immunization in 58 districts / cities. The methods used were lectures, question and answer and field practice. Implementing the evaluation phase was followed by DQS in 58 districts / cities in each sample at least in 2 health centers for each district / city. This activity compares the data at each level, starting from the village to provincial level cohort. From the results of the implementation of DQS, it appears that the accuracy of the data from the village to the health center is still low, while at the health center level to district / municipal and district / city to the provinces are far more accurate. In the assessment of the quality of the results, only 60% was according to the standard.

B. DQS training and implementation in 13 provinces

Data Quality Self assessment and (DQS) in the form of training has been implemented in three HSS provinces and 34 IRI's districts / cities. The methods used were TOT, lectures, question and answer and field practice. Implementing the evaluation phase was followed by DQS in at least in 2 health centers for each district / city, and compares the data at each level, starting from the village to provincial level cohort. From the results of the implementation of DQS , it appears that the accuracy of the data from the village to the health center is still low, while at the health center level to district / municipal and district / city to the provinces are far more accurate. In the assessment of the quality of the results, only 60% was according to the standard.

3. Objective 3 : Improve immunization staff competency through strengthening implementation of MCH-Immunization material for midwife institution

The challenge in the presence of inadequately of health personnel, high employee-turnover and low "working staff retention rate", impacted to high demand on "in service training" , requires an immediate answer. Join review conducted by MCH-EPI program with the center for training of health personnel to concluded that there was an urgent need for Strengthening midwifery training institution for implementation of MCH-Immunization material for midwives, By end 2014, this activities will result in 51 midwifery training institutions.

A.
Technical orientation of improvement of immunization coverage through Midwife TBA Partnership in Public Health Center with Low Coverage

The midwife and TBA partnership has long been performed, yet the impelementation is still not apt with the expectation si

nce there has not any agreement on the form of that partnership; therefore the midwife and TBA are still carrying out birth delivery respectively thus made the childbearing and childbirthing mothers, as well as mothers in parturition period have not received a safe and pleasant service as their wish. The objective of this activity is to evaluate the conducted partners hip forms within respective district/city and assess the effectiveness of the partnership result performed, also to discover t he problem and obstacle in the partnership implementation and seek for problem/obstacle solving deliberately. This activi ty was conducted in form of meeting in district/city with methods of speech, Q and A session, interactive discussion, and group assignment and simulation suitable with the needs which was facilitated by resource person from distrct/city.

Midwives provide continuous service and comprehensive, focusing on aspects of obstetric care, prevention, and promotion, building partnerships and community empowerment with other health workers to provide quality services based on community needs. In order to ensure those services, there is required standard of profession as a reference to do all acts and care provided in all aspects of service to individuals, families and communities, on the input, process and output (decree of the Minister of Health no. 369/MENKES/SK/III/2007). Independent Midwives Practice is one of the main providers of primary health care services that is the foundation of improved maternal and child health. Therefore, midwives are required to be competent in providing midwifery services. Competent midwife is the result of experience and midwifery education process. Thus, the competence of midwife is determined by their midwifery educations , of which one them is the curriculum on midwifery skills that can provide midwifery services to the community , particularly focusing on the achievement of the optimal health status of mothers and children. Thus , it is necessary to see a clear picture of factors that support the capabilities and competence of midwives in providing services to the community, particularly from the midwife providers (midwifery education institutions). Based on the that picture, appropriate interventions to improve the capability and competence of midwives can be taken.

The purpose of this activity:

1. Obtaining an overview of the knowledge of midwifery students on matters related to essential maternal and child health and immunization.

2. Obtaining an overview of learning processes encountered at the level of midwifery education institutions.

3. Obtaining an overview of technical problems faced by midwives in their real health duties.

The activities that are being done:

1. Initial consolidation study

2. preparation of Instruments

3. Instrument trials

4. instrument repair

5. the necessary permits

6. Training of Data Collectors

7. Data collection at the Institute of Education Midwives and Health Care Facilities

The prorgress of ongoing activities until the third week of May 2013

1. Data processing

2. Reporting

Dissemination the results of activities was held the fourth week of May 2013. The results of this study were expected to contribute to illustrate the problems of midwives ability and competence, which in turn, would focus on strengthening interventions in evidence-based policy in improving the capability and competence of midwives (evidence based policy) in providing midwifery services that focus immunization and health mother and child.

B. Integrated MCH and immunization Management Training at HCs

This training was conducted in 5 days, where facilitators provided material presentation and simulation with visual aid wit h basic material consisting basic policy of public health center as well as to form working group; the essential material co nsists of integration of MCH program and immunization within Public Health Center management, planning, mini worksho p, performance appraisal, and other supporting material consisting RTL (Follow Up Plan) and BLC (Building Learning Co mmitment).

Activity outcomes:

• Forming of working group in the public health center

• Planning of annual activity in public health center especially in sector of MCH and immunization

• Analysis for every outcome of MCH program and immunization

•
Forming of consensus i.e.: socialization on the outcomes of public health center management training to all staff; draf ting vision and mission of public health center; data collection upon evaluation of activity outcomes for 1 year; improv ement of performance after working group formed; forming working group in order to compose RUK (Activity Proposa l Plan) and evaluation; conducting the first monthly mini workshop to compile RUK (Activity Proposal Plan), RPK (Acti vity Implementation Plan), and POA (Plan of Action) year 2013; improvement of program integration in attempt to imp rove public health center performance; monthly report received by Health Office at the 5th of next month at the latest; also agreed the color for year 2013 for PWS (Local Area Monitoring) graphic. (Impact?)..

C.
TOT (Training of Trainer) Public Health Center Management in attempt to improve the coverage of MCH and immuni zation. In order to manage health efforts optimally, public health center is obliged to perform good management. Publ ic health center management is an activity performed systematically to produce public health center outcome by mea ns of effective and efficient. Public health center management consists of (P1) Planning, (P2) Mini Workshop, (P3) P ublic Health Center Performance Appraisal. The entire activities above were one related, reciprocal, and continuous unit. As for the objective of this activity is the series participants were expected to be able to become the trainer in the Public Health Center Management Training in terms of Improvement of MCH and Immunization Coverage.

Activity outcomes :

· Participant listed as management facilitator of Public Health Center in District/City.

· Participant socializes the training outcome to the entire cross sectoral program in respective District/City Health Office.

.
Participant follows up the training outcomes in coordination with related cross sectoral program by performing technic al guidance of Public Health Center management in the Public Health Center, (Impact?)

D. Training of Cadres

Community participation is very much necessary in improving the coverage of immunization and MCH, and in order to mo bilize the community, a trained MCH HC cadre is needed. Health cadre in village/MCH HC is volunteer who can facilitate access for community and health worker to obtain health services. In practice, cadre gives elucidation, also acts as an act ivator and motivator for childbearing mothers and mothers with babies; therefore it is necessary to equip and to increase t he cadre's concept in infant health care. The objective of this activity is to escalate the cadre's capacity concerning baby' s health in attempt to improve immunization coverage.

Activity outcomes :

• Improving cadre's capacity

• Cadre can give information concerning child health to the community correctly

• Cadre can have early detect on mother and child

• Escalating the community empowerment so that the immunization improved

• Can detect any malnutrition early

E. Drafting training curricular for child health cadres

The activity of improving the cadre's capacity on infant health in the attempt to improve the coverage of immunization nee ds implementation guideline and standardized curricula to maintain the outcome of the arranged training

This activity produced curricular module for training of child health cadres.

F.
District level comprehensive training of the health center staff on Immunization and MCH program management in th e all districts in Riau, Riau Islands, Bengkulu, West Sumatera, All Kalimantan Provinces

· The training took place at the provincial level. The participants were officers of hospitals implementing immunization services. The targeted hospitals in this training are the Government General Hospital, private hospital, military/police hospital, and state hospital located in those 3 provinces. Out of total 305 hospitals that are targeted to be trained in 2012 only 64 were trained, while the remaning 241had it in January-April 2013.

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District level comprehensive training of the health center staff on Immunization and MCH program management in th e all districts in Riau, Riau Islands, Bengkulu, West Sumatera, All Kalimantan Provinces

In 2012, the training was conducted in 2 provinces through TOT system. Participants of this training were immunization program exocutors, MCH and health services executors at district/city level, and HC personnel that included MCH and immunization program managers. This training involved Health Training Centres (Bapelkes) of the 2 provinces to guarranty a good quality of training. In 2012, training in the province of Riau has been implemented for all personnel district / city, while training for clinic staff (TOT) was conducted in January-
April of 2013. Training in Bengkulu province has been implemented for the entire clinic staff of 86 health centers in 6 districts / cities. Training for the rest of the existing health centers in four other districts in Bengkulu was implemented in January-
April of 2013. Aside from the two provinces, in the period of January to April of 2013, there were also comprehensive management trainings on immunization and MCH in 6 provinces, namely West Kalimantan, Central Kalimantan, East Kalimantan, South Kalimantan, West Sumatra and Riau.

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:

PROGRAMMATIC PROBLEMS:

1. TThe numbers of trained cadres were still very insufficient within respective district due to lack of funds for training of cadres

2. The child health book for cadre and IEC material/cadre's supporting kit (returning form) were not enough for the total cadres within the district.

3. The process of mutation and rotation make the implementation of management personnel at the health center to be unoptimal

4. Partnership: A varied number of non government agencies for partnership need different advocacies. In 2011, Most o f 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

MANAGERIAL PROBLEMS:

1. Due to reprogrammings, the implementations and reportings of the project programs were not ontime

2. With the extended time of the HSS to year 2014 and the expansion of the provincial and district level makes the proje ct cost management insufficient.

Alternative Solution :

1. Need for additional funds for cadres training
2. Budgeted funds for book printing activities
3. Reform HC Management Team (new policy)
4. Enhance the ME through 3 monthly meetings withlocal as well communications to the GAVI personnel at provincial/district/citylevel
5. Trainers from central level give trainings forsome non government organizations that take part in partnership activities. Asfor the partnership with IBI (Indonesian Midwife Association), PKK (FamilyWelfare Education), and ongoing midwife – TBA partnership, this has obtained acommon cooperation to work together with health institutions, supported by GAVICSO fund.

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

1. Central level :

-

The progress 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 of Treasury State Office.

-

GAVI Grant implementing team works at each implementing unit and secretariat. The monitoring and evaluation officers also work at Secretariat of Directorate General who is appointed by the Director General Decree, thus avoiding a frequent replacement of staff. The activities include with:

–Coordinating the audit of external auditor (Badan Pengawasan Keuangan dan Pembangunan/BPKP) activities

–Integrated monitoring at provincial/district/city level

- DG of Nutrition and MCH monitors/assists the process of fund accountability at the province and selected districts
- The ME team will work with project management each monthly to monitor the progress.

-

The head of Bureau of Planning and Budgeting of MoH as part of HSCC board carry out quarterly meeting among implementing units and report to HSCC board

-

The Quarterly Report is also 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.

- At least twice a year coordinative meeting among related units and provincial/district level
- At least 4 times a year the HSCC (Health Sector Coordinating Committee) conducts regular meeting

2. Provincial level :

-

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 Treasury State Office as a basis for releasing SP2HL

-

In provincial level also has ME team whose members are assigned by Director General of CDC Decree (to avoid a frequent replacement of staff) is responsible to monitor activities at provincial/district/city level

-

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

- Monitoring and evaluation covers up to the district/city level
- The province takes part in almost all activities at districts/cities level
- The province consults to the central level
- At least twice a year coordinative meeting at provincial level and district level

3. Districts/Cities level :

- Monitoring and evaluation officer that works at district level is responsible to monitor the activities at district/city and

Public Health Center level

- Districts/cities Monitoring evaluation team is set up by Decree of Head of Provincial Health Office

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District Health Office (monitoring and evaluation team) conducts monitoring and evaluation of activities at the selected H ealth 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.

Monitoring Implementation of Activities:

1. Central Level:

- Bureau of Planning and Budgeting, MOH monitors the implementation of GAVI HSS

-

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

- National Planning and Development Board monitors the activities of the GAVI HSS

- Technical Team of GAVI routinely monitors the implementation of GAVI HSS

-

Integrated National Monitoring and Evaluation System: GAVI HSS activities are reported together with the monitoring implementation of State Budget – funded activities

2. 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 repo rt to the secretariat of GAVI HSS, who will then recapitulates this report to and submit it to the program manager. This re port goes to the State of Treasury Office of Ministry of Finance every quarterly period for Direct Grant Approval Letter.

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

1. CSO

a. PKK (Family Welfare Educational class), an organization of mothers, has activities such as:

-

Disseminating MCH information during monthly wives gathering where DHO staff has opportunity to speak about MC H and immunization

- Activating “Dasa Wisma” (a group of 10 t0 20 neighborhoods) in South Sulawesi province

b.

White Ribbon Alliance, a community organization of persons who concern about maternal health services. This organ ization spreads around Indonesia, and in Banten Province, it actively involves in socializing MCH booklets to housewi ves, including information about pregnancy routine checks

c. BPS,a private midwifery practice, is active in reporting MCH service and immunization data to the Health Centers.

2. Religious organizations

a.

ALHIDAYAH and MUI are two Islamic organizations that spread across the country and are active in disseminating in formation about MCH booklets using as well as reproductive health among youth.

b.

AISYAH and Fatayat NU, a wives organization where during their monthly Islamic oration they invite a speaker from t he DHO to speak about MCH and immunization issues.

c.

PERDAKI, Injili Christian Church, are two organizations in Papua province that take part in socializing the MCH bookl ets using and informing health and immunization schedules at Posyandu (integrated Health Post) at the end of the ch urch service.

3. Private companies

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

Academic Institution : University of Indonesia, Gadjah Mada University, Hasanuddin University, Padjajaran University, Ce ndrawasih University. They were assigned to analyze data of survey (VM and SAM). Gajah Mada University also under t ook 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)

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 guaranty for delivery in health facilities)

2. PKK (Family Welfare Educational Class)

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

3. Community figure/religious leader

Type of activities : GAVI HSS pay for training of religious/community leaders in BPCP & using of MCH handbook, then th ey implement in their religious/community activities

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 in MOH (Directorate General of Nutrition, Maternal and Child Health, Directorate Surveillance and Immunization, Center of Health Promotion and Human Resource Development Body). This meeting followed with the Provincial Health Office and District Health Office meeting to allocat e the funds by using standard cost from the Ministry of Finance as well as local standard cost.

1.Mechanism of channeling of GAVIHSS funds into the country:

GAVI Geneva transfers the money to the executing agency's account number (Directorate General of Communicable Dis eases and Environmental Health)

2. Transferring mechanism of GAVI HSS funds is as follows:

a.
After PoA approved by DG of DC & EH as Project Manager, the Budget plan will be stated on State Budget Document of each implementing units which is approved by MoF. This means that all GAVI expenditure will be subjected on aud it by regular auditor (internal and external auditor)

b. The fund will be transferred to each implementing unit's bank account by DG of DC & EH.

3. Fund channeling mechanism from central level to provincial and district level:

The funds are transferred to province and districts health office after PoA approved by each Authorized Budget of unit im plementing. Prior to the transferring, the head of PHO/DHO must sign the letter of integrity pact. This mechanism was als o applied by all implementing units at central level

Mechanism of budget used and approved:

The used of GAVI HSS funds by each implementing units at central level and provincial/district level to conduct activities should in-
line with the action plan or detailed plan budget approved by DG of CD & EH. The Program manager is responsible to en sure that the budget is used on the right track. The head of implementing units (central level and PHO/DHO) submit mont hly Financial Report to the Program manager of GAVI HSS and to the DG of CD & EH. Program manager submit financia l report to Authorized Budget, then report will be sent to get legalization (SP3) from the Special Treasury Office-
Jakarta VI with attached documents of recapitulation of the expenditure and the bank statement

Mechanism of disbursement of the GAVI HSS funds :

The funds are transferred to province and districts health office bank account after the head of each implementing units a nd PHO/DHO signed the letter of integrity pact.

Auditing Procedures:

The auditing procedures refer to the Government of Indonesia regulation on audit mechanism. An internal audit is conduc ted by the Inspectorate General of Ministry of health, and an external audit isconducted by The Government's Internal Au ditor 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 Progra m Manager will pass it to the Director General of Communicable Disease and Environmental Health for approval. Revisio n is permitted for an adjustment of unit cost only. While the activities proposed must not change.

Constraints :

- Long Bureaucracy (fund planning, fund disbursement, budget claiming, accountability of budget use and its approval)

- Mechanism differences (and accountability) of budget use at central and provincial/district level.

Action taken/Suggestion :

- New management team, including staff recruitment for new secretariat

-

Budget allocation are made under the relevant DG (shifting fund disbursement authority from the DG of Communicab le Disease & Environmental Health to the DG of Nutrition and MCH)

- Planning & monitoring meeting at various levels to solve problems

Change to management processes in the coming year

-

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.

-

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

9.5. Planned HSS activities for 2013

Please use **Table 9.5** to provide information on progress on activities in 2013. If you are proposing changes to your activities and budget in 2013 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned 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)	**2013 actual expenditure** (as at April 2013)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
Obj.1	Area with low immunization coverage through acceleration of immunization coverage in low coverage area					
Intersectorial socialization and advocacy district meeting in 97 districts (62 of the weak districts of the 5 provinces under the ongoing HSS and in 36 districts with the higest number of non UCI (Universal Childhood Immunization) villages under the IRI (Intencification of Routine Immunization). See annex for list of district	1. Coordination meeting with provinces and districts which have the highest number of non UCI (Universal Childhood Immunization) villages and also are the IRI areas	47740	45209			

ntersectorial socialization and advocacy district meeting in 97 districts (62 of the weak districts of the 5 provinces under the ongoing HSS and in 36 districts with the higest number of non UCI (Universal Childhood Immunization) villages under the IRI (Intencification of Routine Immunization). See annex for list of district	2. Strengthen routine immunization through Drop Out Follow up Immunization (DOFU)	484236	436346			
ntersectorial socialization and advocacy district meeting in 97 districts (62 of the weak districts of the 5 provinces under the ongoing HSS and in 36 districts with the higest number of non UCI (Universal Childhood Immunization) villages under the IRI (Intencification of Routine Immunization). See annex for list of district	3. National media workshop to sensitize 44 journalist from the 22 identified provinces (5 HSS Provinces, 10 IRI Provinces and 7 provinces in Sumatera that not include as IRI provinces) ensure public awareness and complient. The workshop to be supported by media campaign in these provinces/districts.	38832	38832			
ntersectorial socialization and advocacy district meeting in 97 districts (62 of the weak districts of the 5 provinces under the ongoing HSS and in 36 districts with the higest number of non UCI (Universal Childhood Immunization) villages under the IRI (Intencification of Routine Immunization). See annex for list of district	4. Immunization Public service anouncement	283614	255934			

Develop and distribute IEC material and social mobilize on immunization and maternal and child health with local content for the hard to reach and mountainous area of papua and west papua province.	1. The development of media of Commmuicati n, information and Education on Neonatal and Imunization by accommodatin g local wisdom, in remote Papua and West Papua	31037	24036			
	2. Procurement and distribution of MCH books for Islamic organizations, whose contents are based on the Islamic views/Al Quran	23122	12183			
Printing & Distribution of Buku kader seri kesehatan anak, Buku Saku Pelayanan Kesehatan Neonatal Esensial and caders training modules for the 5 indentified HSS province		38832	33363			
Increase Integrated Planning to increase immunization and MCH coverage in low coverage areas	1. Mid term review meeting on Immunization and NMCH Coverage at district low coverage area, and to identify villages with low coverage area using LAM	54693				
	2. Conducted DOFU and sweeping in the identified 56 districts in the 15 provinces with low coverage	711004				
	3. Reach un-immunize children whose live at the hard to reach area using SOS strategy (200 village at 100 PHC)	765697				

	4. Supervision and technical assistance for the low coverage and hard to reach province/district	191424				
Increasing Public Awareness	1. Promotion on Immunization using IEC Material to mothers and caregivers of unimmunized and uncomplete immunized children	218771				
	2. Using FlipChard Health Children's Series for Cadre adaptation for Papua and West Papua	54693				
	3. Using Jingles to increase awareness on Immunization and MCH	27078				
	4. Improving cadre involvement in community mobilization for immunization and MCH services	75121				
	5. Partnership with TBA and private midwives to increase immunization coverage	75077				
Cold Chain Improvement		346071				
Obj.2	Capacity Development on ensuring data collection and reporting					
Revise and standardize tool for reporting and recording individual resistrations (hard and soft) at health centre level		48121				
Refreshing training and implementation of DQS at all districts in provinces (West Sumatera, Lampung,Central Java, Bengkulu)		259452	150067			

Strengthening of Reporting and Recording by integrated Individual registration System (Implementation of web-based RR)		164077				
Obj.3	Improve immunization staff competency through strengthening implementation of MCH-Immunization material for midwife institution					
Review & revise the immunization and MCH component in the midwife academic curriculum & introduce in the 51 midwife in the 5 identified HSS Provinces		106520	13847			
District level technical orientation and sensitiztion of Immunization and MCH by partnering midwives and village TBA in two fo the HSS provinces of West Java and South Sulawesi.	1. Technical orientation to improve immunization coverage at low coverage HCs, through midwife-TBA partnership.	14392	14390			
District level comprehensive training of the health center staff on Immunization and MCH program management in the in 34 of the 4 identified HSS provinces - West Java (13 District), South Sulawesi (18 District), Papua (1 District) and West Papua (2 District)	1. Comprehensive MCH and immunization management training at HCs	119739	105665			
	2. TOT of HC management to improve MCH and immunization coverage	118				

District level training of cadres on basic immunization and maternal and child health practices in the 32 districts of the identified 4 HHS provinces - West Java: 14 district, South Sulawesi 14 District, Papua (2 District) and West Papua (2 District)	1. Cadres Training	238701	229864			
	2. The development of curriculum for cadres of child health	4254				
	3. District level comprehensive training of the health center staff on Immunization and MCH program management in all districts in Riau, West Sumatera, and All Kalimantan Provinces	161200				
Province level comprehensive training for districts and health center staff on Immunization and MCH program management in Riau, Riau Islands, Bengkulu, West Sumatera, All Kalimantan Provinces		542869	529583			
Management training for immunization program for 305 hospitals in 3 HSS Provinces (West Java, Banten and South Sulawesi) including post training monitoring and evaluation		75072	75072			

Immunization Program Management Training for 305 hospitals in 3 Provinces (West Java, Banten and South Sulawesi) including post-training monitoring and evaluation		114198				
Collaboration with education institution (School of Medicine, School of Public Health, School of Midwifery and School of Nursing) to increase immunization and MCH services coverage		109385				
Material of curriculum for Midwifery Teaching Program		63528				
Asssesment and developing Training Modul for Midwive Institution on “Strengthening of the Implementation of Immunization and MCH Material"		75125				
SUPPORT COST		816522	76472			
		6380315	2040863			0

9.6. Planned HSS activities for 2014

Please use **Table 9.6** to outline planned activities for 2014. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval 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 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (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 2014** (if relevant)
		0			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

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 full fill the tools.- Tools were full filed by responsible person for GAVI HSS at district level to be then recapitulated 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/PHOFinancial Report : - District Health Office sent the Financial Report to PHO. - The recapitulation of the report was 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 report was 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 region s,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 2012?2

Please attach:

1. The minutes from the HSCC meetings in 2013 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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 23)**

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.

This information has been reported in APR 2011,thus will not be described in this APR.

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 Indinesian 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
Tuminah Wiratnoko	Treasure of indonesian Midwaives 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 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	0	0
Remaining funds (carry over) from 2011 *(B)*	0	0
Total funds available in 2012 *(C=A+B)*	0	0
Total Expenditures in 2012 *(D)*	0	0
Balance carried over to 2013 *(E=C-D)*	0	0

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 Midwives Association
IDAI	:	Indonesian Pediatrician Association
IMC	:	International Medical Corps
Kuis	:	Coalition for Healthy Indonesia
Gerakan Pramuka.	:	Indonesian Scout Movement
MoH	:	Ministry of Health
PPAisyiyah	:	Central Board of Aisyiyah
PP Muslimat NU	:	Central Board of Muslimat Nahdlatul Ulama
YKAI	:	Indonesian ChildWelfare Foundation
PATH	:	Program for Appropriate Technology in Health
Perdhaki	:	Association of Voluntary Health Services in Indonesia
Pelkesi	:	Association of Christian Health Service in Indonesia
PKBI	:	Indonesian Family Planning Association
TP-PKK	:	Family Welfare Movement
Cons	:	Consortium
CHP	:	Centre for Health Promotion
GP	:	Gerakan Pramuka

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.

Progress of Implementation:

4 CSOs(TP.PKK, Gerakan Pramuka, Konsorsium, IBI) started conduct Phase 2 activitiesin 2012.

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

1. TP.PKK (May – December 2012)
2. Gerakan Pramuka (June- December 2012)
3. Consortium (Mei – Dec 2012)

4. IBI (April –December 2012)

1. TP.PKK = FamilyWelfare Movement (May – December 2012)

a. Coordination meeting in Provincial level.

The coordinationmeeting was conducted in 5 provinces (West Java, Banten, South Sulawesi, Papuaand West Papua). The objective is to plan the activity in district level.

b. Midterm review

Midterm reviewmeeting was conducted in Makasssar (South Sulawesi). The participants areTP.PKK Province (5 provinces) and TP.PKK district (10 districts). The objectiveis to agree about plan of action in 5 provinces and 10 districts and supplementary feeding (PMT) in Posyandu.

c. Supporting IEC Media for Cadre PKK and Cadre Posyandu.

Reprinting and distribution Orientation Modul, Manual Book, Information Book for Cadre,Leaflet as media tool for Cadres PKK and Posyandu to explain immunization and mother child health benefit and importance to target appropriate their agegroup.

d. Orientations for cadres

Orientations forcadres were conducted in 6 districts (Sorong, Manokwari, Jayapura, Keerom,Kuningan dan Bogor) at 3 provinces. The objective is to increase knowledge,communication skills, community empowerment and writing immunization activityin Posyandu.

e. Community outreach

Group eludicationby cadres in Integrated Health Post (Posyandu), supplementary feeding and homevisit.

f. Monitoring and evaluation

Monitoring andevaluation conducted in 4 provinces (Banten, West Java, South Sulawesi, WestPapua). GAVI-CSO programmes can improve TP.PKK's roles which are to guide cadres in increasing services in Posyanduand to cooperate with health sector and local goverment. The cadres were helped by guidance book and leaflet.

2. Gerakan Pramuka (June - Dec 2012)

a. Coordination meeting in Provincial level.

The coordination meeting was conducted in 5 provinces (West Java, Banten, South Sulawesi, Papuaand West Papua). The objective is to plan the training of implementation for group leader and special troop instructor.

b. Coordination meeting in district level

The coordinationmeeting was conducted in 10 districts (Depok, Majalengka, Tangerang, Cilegon,Maros, Pangkep, Jayapura, Keerom, Manokwari and Sorong). The objective is to plan the training of implementation for peer group education for rover and senior rover.

c. Training of implementation for group leader and special troop instructor.

The training is conducted in 3 provinces : South Sulawesi (Maros and Pangkep district) Papua(Jayapura and Keerom district) and West Papua (Manokwari and Sorong district).The participants are 25 people from each district. The objective of the training is to be able to train the rover and senior rover in each district.Traning material are Principal and Method of Scouting, Immunization, MCH.

d. Peer group education for rover and senior rover.

The education conducted in 5 provinces :West Java (Depok and Majalengka disticts), Banten(Cilegon and Tangerang districts), South Sulawesi (Maros and Pangkep districts), Papua (Jayapura and Keerom districts) and West Papua (Manokwari and Sorong district). The participants are 20 rovers/senior rovers for eachdistrict. The objective is to be fasilitator in group operational.

e. Group Operational (Gudep)

The activity was conductedin 8 districts (Cilegon, Tangerang ,Maros, Pangkep, Jayapura, Keerom, Manokwari,Sorong). The participants are 40 rovers/senior rovers from 20 group operational(2 rovers/senior rovers each group). The objective is teaching them to be peertrainer in their group operational which each rover will train 20 peers. In2013 these participants will conduct the peer training and then each of them will conduct home visit to 10 families with baby.

3. Consortium

a. Reviewmodules

Conducted review modules on routine immunization and MCH. Consortium has developed 3 types of modules, namely: module for PLM, PSS, and TOM. In total all these modules were printed 1700 books and distributed for training participants. The review involved Centre for Health Promotion, Directorate of Immunization, Agency for Health Human ResourceDevelopment and Empowerment, and Directorate of MCH.

b. Coordinationmeeting

Coordination meeting were held in 3 different level (center, provinces and districts). The objective isto achieve agreement of plan of action.

c. Media Dissemination / Public Campaign.

The media and public campaigns were pocket book, leaflet, standing banner, t-shirtwhich were produced and distributed to 2 provinces and 10 districts.

d. Training

Conducted trainings in 2provinces (West Java and South Sulawesi) in 10 districts. There are 3 types of trainings:Training of health center personnel / training of peripheral level (PLM) for 15 groups, Training of Private Sector Staff (PSS) for 23 groups, Training of Village Cadre/training of Motivator (TOM) for 22 batches.

e. Community empowerment and mobilization

The of communityempowerment are group eludication, home visit by trained cadre/TOM in the village. The target of group eludication were pregnant women and mothers withbaby.

The activitiy of mobilizationis healthy baby contest in 5 district (Sidrap, Jeneponto, Barru, Takalar andSinjai). The participants of the contest werefrom 30 sub districts in each district. One of the contest requirement is the immunizationstatus of baby.

Competition ofcommunication and information skills for the trained cadre/TOM in 2 provinces.The participants of the competition were from 5 districts in each province.

f. Publication

The Consortium publishedand disseminated its activities through mass media (local newspaper, local TV),namely: Fajar Sulsel, Ujung Pandang Express, TVRI, Fajar TV, TV Sinjai (SouthSulawesi); Radar Kuningan, Radar Purwakarta, Purwakarta Express, Radar Ciamis,TVRI Jabar (West Java).

g. Supportive SupervisionImplementation

Supervision was conductedin 4 Districts: Kuningan, Purwakarta and Ciamis (West Java Province); andBarru in South Sulawesi Province). The supervision in those 4 districts revealed that there had been community elucidations in social religious gathering(“Pengajian” and “arisan”). The supervision showed that information about immunization and MCH were comprehended by audience and it was proved by the coverage of immunization.

4. IBI (April – Dec 2012)

a. Conducted midtermreview.

The participants of midterm review are from provincial board of IBI (West Java andSouth Sulawesi), district board of IBI (Bogor, Bekasi, Enrekang, Palopo andLuwu Timur), Centre for Health Promotion, Directorate of Immunization, Directorate of MCH andSKIPI. The meeting objective is to inform progress activities 2011 and to plan Phase2 activities.

b. Coordinationmeeting

Coordination meeting were held in 3 different level (center, provinces and districts). The objective is to achieve agreement of plan of action.

c. Conductedrefreshing/micro teaching for midwives/nurses

Themicro teaching is given to midwives/nurses who were trained in 2011. They gottrained about technic and method of training. The micro teaching was conductedin 5 districts. In the next step, micro teaching participants from district levels wil train cadres/traditionalnurse (“dukun”). In the year 2012, the trainings for cadres/”dukun” were conducted in 50 villagesin Bogor district (50 villages remaining from 100 targetvillages in 2011), 100 villages in Bekasi district, 60 villagesin Enrekang district, 50 villages in Palopo district, and 55 villages in LuwuTimur district.

d. Dissemination of IEC Media

The media development involved Centre for HealthPromotion, Directorate of Immunization, and Directorate of MCH. The media areleaflet, booklet, pin, flipchart, bag and t-shirt. The media are distributed to 2 provinces and 5 districts. Target of the media aremidwives, cadres/dukun, pregnant women and mothers with baby.

e. Conducted training for cadres/dukun

The training is conducted in sub district level in 5 districts. The number of participants are 250 cadres/dukun in Bogordistrict, 500 cadres/dukun in Bekasi district, 300 cadres/dukun in Enrekangdistrict, 250 cadres/dukun in Palopo district and 275 cadres/dukun in Luwu Timurdistrict.

f. Community Outreach

Village midwives, who have been trained, conducted group elucidation in Integrated Health Post (Posyandu). Cadres/”dukun” conducted groupelucidation and home visits using IEC media. The target of group elucidation is pregnant womendan mothers with baby.

e. Monitoring andEvaluation

Monitoring and Evaluation (Monev) was conducted in 5districts and Posyandu. Monev is implemented by field visits, observation and interview using questionnaires. The monev results are GAVI-CSO programs has buildgood relationship network betwen IBI and local goverment, cadres/dukun areexcited having increase knowledge about immunization and MCH after training.

Implementing Agency(Center for Health Promotion, MoH):

1. 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 three times in 2012.

2. Developed and produced GAVINewsletter

There are 3 edition of GAVI Newsletter have been published in 2012, which covered activities of all 3 components of GAVI Phase II inIndonesia.

3. MidtermReview

Midterm review wasconducted to evaluate the activitiesof GAVI-CSO Phase l, to coordinate and integrate the activities that will be implemented in the Phase II so that the CSOs and program holders support each other in improving immunization coverage and MCH. Midterm participants came from four CSO (TP.PKK, Scout Movement, Consortium and IBI) central, provincial and district; and also inter-related programs of Provincial Health Office, District Health Office of intervention areas.

The results ofthe meeting are the description of activity implementationby each CSO and input for the

implementation of GAVI-CSO program Phase II.

4. Conducted Monitoring andEvaluation (Monev)

The monitoring and evaluation were conducted only in two provinces, West Java and South Sulawesi.The activity was aimed to monitor and evaluate whether CSOs (TP.PKK, IBI andConsortium) in provincial and district level conducted coordination with the Health Office in provincial and district level. It aims also to identify problems encountered during implementation of the program, and provide recommendation.

Monitoring and evaluation in West Java and South Sulawesi revealed no significant problem found and that all CSOs (TP.PKK, IBI and Consortium) inprovincial and district level had good coordination with the Health Office in provincial and district level. CSOs activities went well 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 inimplementing the activities is the Center for Health Promotionwithin MoH Indonesia. While the GAVI Alliance CSO Support is implemented by Gerakan Pramuka, TP PKK, Consortium and IBI.PP Muslimat NU is the lead 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 strengthening their collaboration in immunization and MCH services. MoH is not only channeling financial support, but also technical support for all CSOs involved. Each CSO invited other CSOs and program holders (Directorate of Nutrition, Directorateof MCH, and Sub directorate of Immunization) on each of their coordinating meetings where they can share data and provide inputs. For instance, IBI and Consortium's baseline data were acknowledged by MoH to complement their data for future 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 CSO involvement in Immunization and health system strengthening. In 2012, participants that had been trained by 4 CSOs: Gerakan Pramuka, TP. PKK, IBI and Consortium empowered and mobilized the community in immunization and MCH. For example in IBI: cadres thathad 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 for 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 (Association of Indonesian National Nurse) for the implementation programs and Consortium involves PPPKMI/Perkumpulan Pendidik dan Promotor Kesehatan Masyarakat Indonesia (Indonesian Society of Health Promotor and Educator) for baseline data survey, 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 implementations and CSOs' abilities to meet the milestones stated on the proposal and Plan of Action.

Trainers of PKK and Gerakan Pramuka had been trained in 2009 but train their cadres and scouts in2012. The delay probably will influence the quality of trainings.

Managers who have been trained already changed so need re-training.Likewise PKK cadres in 4 districts, which has intervented in the first term funding,need to be re-trained.

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 2012	Outcomes achieved
Consortium (PP Muslimat NU, PP Aisiyah, Perdhaki) – Religious Based Organization; Empowerment Orientation; National Operation	MCCI Project as stated on APR 2010	1) Working Group Meeting 2) Review Modules on routine immunization and MCH. 3) Training of health centre personnel / training of peripheral level (PLM). 4) Executive Level Staff Training private sector (PSS). 5) Cadre Training Village Level; Training of Motivator (TOM) 6) Community Outreach:	1) Coordination meeting at central level, Province level, district level 2) Modules for PSS, PLM, and TOM 3) 378 people (PLM) trained and skilled about routine immunization, maternal child health, community empowerment.4) 578 people (PSS) trained and skilled about routine immunization, maternal child health, community empowerment. 5) 602 people (TOM/cadres) trained and skilled about routine immunization, maternal child health, community empowerment. 6) Community Outreach
Gerakan Pramuka (Participatory Orientation; National Operation)	MCCI Project as stated on APR 2010	1) Coordination meeting in Provincial level. 2) Coordination meeting in district level. 3) Training of implementation for group leader and special troop instructure. 4) Peer group education for rover and senior rover. 5) Group Operational (Gudep)	1)Plan of Action for training of implementation for group leader and instructure 2.) Plan of Action for training of implementation for peer group education for rover and senior rover. 3)c. 150 group leader trained scout leaders train. 4) d. 200 rover and senior rover 5)e. 320 rover scout train
IBI (Professional Organization; Empowerment Orientation; National Operation)	MCCI Project as stated on APR 2010	1) Refreshing/microteaching for midwives and nurses from provincial and district level. 2) Training for cadre and dukun sub district level 3.) Produce and distribute IEC Media to 2 provinces and 5 districts. 4) Community Outreach :	1) 511 midwives and nurses in district trained. 2) 1.575 cadres in sub district level (in Bogor, Bekasi, Enrekkang, Palopo, Luwu Timur) trained. 3) Leaflet 20.000 pcs, Pin 20.000 pcs, T-shirt 2.200 pcs, Flipchart 1.500 pcs, Bag 1.500 pcs, Standing banner 100 pcs. 4) Comunity Outreach :
NA	NA	a) Posyandu coaching meeting by midwives and cadres. b) Monthly meeting and technical couching in Posyandu. c) Community elucidation by midwives/nurses. d) Home visit elucidation by cadre using IEC media. e) Socialization activities through meeting, program launching and campaign. f) Agreement reached about the program comprehension and action planning implementation program. 5) Monitoring and Evaluation in 5 districts and Posyandu in each district	a) Community elucidation in Bogor : 2500 home visit, Enrekang : 3.000 home visit, Palopo : 2.500 home visit, Luwu Timur : 2.750 home visit. b) Socialization and Advocacy in 53 sub districts and 315 village level. c) Information dissemination through IEC media. d) Plan of Action for cadre training in 315 villages and community education, home visit by cadres. 5) Monev report and documentation
NA	NA	5) Monitoring and Evaluation in 5 districts and Posyandu in each district.	5) Monev report and documentation
NA	NA	7) IEC Media/ Public Campaign 8) Supportive Supervision Implementation 8 district (Sidrap, Barru, Jeneponto, Ciamis, Kuningan, Cimahi, Purwakarta and Sukabumi)	7) Produced and distributed 8,000 Pocket Book, 15.000 leaflet, 9000 T-shirt and 400 standing banner. 8) Report and documentation
NA	NA	a) Socialitation Contest. b) Healthy Baby Contestc. Group Eludicationd. Home visite	a) 3 contest winner from each province in west java and south sulawesi b) 3 contest winner from each province in west java and south sulawesi c) 2772 group eludication d) 2772 cadres home visite

TP PKK (Women Empowerment Orientation; National Operation)	MCCI Project as stated on APR 2010	1) Coordination meeting. 2) Midterm review. 3) Orientations for cadres. 4) Community outreach. 5) Monitoring and Evaluation	1) Plan of Action in district level. 2) Plan of Action for community outreach. 3) Oriented cadres in 6 districts (Sorong, Manokwari, Jayapura, Keerom, Kuningan dan Bogor. 4). Community Outreach : a) Group eludication by cadres in Posyandu. b) Supplementary feeding. c) Home visit. 5) Monev report and documentation Monev report and documentation

Please list the CSOs that have not yet been funded, but are due to receive support in 2012/2013, 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 2012/2013

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2012/2013	Expected outcomes
Every CSO received disbursment on 2012	Increase awareness of immunization program among mothers	2649936	community empowrment

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.

1. Gerakan Pramuka

Joedyaningsih

Hp.081287887844 email : kwarnas@centrin.net.id / joedyaningsih_sw@yahoo.co.id

2. TP.PKK

Susi Soebekti

Hp.08131488828 email : secretariat@tp-pkkpusat.org

3. Consortium

Khofifah Indarparawansa

Hp. 08111004197 email : khofifah_ip@yahoo.com

4. IBI

Tuminah Wiratnoko

Hp. 0811780031 email : ppibi@cbn.net.id / tuminahwiratnoko@yahoo.com

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 2012 year

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	2,649,936	2,377,278,642
Remaining funds (carry over) from 2011 *(B)*	40,688	364,250,352
Total funds available in 2012 *(C=A+B)*	2,690,624	2,741,528,994
Total Expenditures in 2012 *(D)*	1,387,334	1,254,328,316
Balance carried over to 2013 *(E=C-D)*	1,303,290	1,487,200,678

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.

* For table 10.2.4 (local currency) in thousand because the digits in the table for the local currency is not enough.

The type B fund was included in national planning and budgeting. Thetype B fund was channeled to 4 CSOs (IBI, Consortium, PKK and Gerakan Pramuka) and to secretariat management of GAVI CSO in Center for Health Promotion. Each CSO must submit the financial report every 3 months to Center for Health Promotion MoH through secretariat management of GAVI CSO. The bank which is used by the secretariat management is Bank Negara Indonesia 46 (BNI 46), while other 4 CSOs use different bank (Gerakan Pramuka uses Mandiri Bank, PKK uses BNI 46Bank, Consortium uses BRI Bank, and IBI uses BNI 46 Bank).

Detailed expenditure of CSO Type B funds during the 2012 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2012 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	Accomplished	2012	3	2012
CHP 2.GAVI Newsletter	Availability of guidance	Centre for Health Promotion	N.A	Accomplished	2012	3	2012
CHP 3.Midterm Review	Availability of attendants	Centre for Health Promotion	N.A	Accomplished	2012	1	2012
CHP 4.Monitoring and evaluation	Monev report available	Centre for Health Promotion	N.A	4 provinces	2012	4	2012
Cons 1.Working Group Meeting	Coordination Meeting of the Working Group Phase II	Consortium report	N.A	Accomplished for 2012	2012	2	Oct 2013

cons 10. Executive Level Staff Training private se	Increased knowledge and skills of Private Officers	Consortium report	N.A	1028 trainers (58,4%)	2011-2012	1760	Oct 2013
cons 11.Monitoring Evaluation	4 times a consolidated monitoring the implementati	Consortium report	N.A	Accomplished for 2012	Dec 2012	100	2013
cons 12. Cadre Training Village Level; Training o	Trained 1280 people motivator/cadre about routine	Consortium report	N.A	1026 trainers (63,6%)	2011-2012	1280	Nov 2013
cons 13. Media Dissemination / Public Campaign	-Media campaign distributed : 10,000 T shirt, 2,0	Consortium report	N.A	2000 Leaflet (100%)	N.A	2000	N.A
cons 14. Media Dissemination / Public Campaign	-Media campaign distributed : 10,000 T shirt, 2,0	Consortium report	N.A	10000 T-Shirt (100%)	N.A	10000	N.A
cons 15. Media Dissemination / Public Campaign	-Media campaign distributed : 10,000 T shirt, 2,0	Consortium report	N.A	2000 banners (100%)	N.A	2000	N.A
cons 16. Media Dissemination / Public Campaign	-Media campaign distributed : 10,000 T shirt, 2,0	Consortium report	N.A	2000 pins (100%)	N.A	2000	N.A
cons 2. Beginning and End of Data Collection routi	- Availability of data End routine immunization co	- District health office data - Qualitative data	N.A	Accomplished for beginning of data collection	Data collection finished in Dec 2010	100	Nov 2013
cons 3. Socialization and Workshop at the Center &	- Socialized GAVI CSO Consortium Program in South	Consortium report	N.A	Accomplished	Nov 2010	100	Nov 2010
cons 4. Training Modules on routine immunization a	Establishment of integrated training modules on ro	Consortium report	N.A	Produced and distributed	2011 - 2012	3200	N.A
cons 5. Supervise preparation of the instrument of	Check list preparation of supportive supervision	Consortium report	N.A	Accomplished	2011	100	2011
cons 6. IEC Books/Guides and Routine Immunization	Produced and distributed 10,000 Regular Routine Im	Consortium report	N.A	10000	2011-2012	10000	2012
cons 7. Training Leader/ manager Provincial Level	35 people trained and skilled about routine immuni	Consortium report	N.A	35 trainers (100 %)	2011	100	2011
cons 8. Training Leader / Manager District Seconda	70 middle-level managers to increase their knowled	Consortium report	N.A	70 trainers (100 %)	2011	70	2011
cons 9. Training of health centre personnel / trai	- Increased knowledge and skills of health center	Consortium report	N.A	645 trainers (100%)	2010-2012	645	2012

GP 1.Coordination meeting in provincial level	Training of implementation for group leader and sp	Kwarnas Report	N.A	5 Provinces	June 2012	5	2012
GP 2.Coordination meeting in district level	Peer group education for rover and senior rover	Kwarnas Report	N.A	10 Districts	Oct - Nov 2012	10	2012
GP 3.Training of implementation for group leader	Increased knowledge and skills of immunization cov	Kwarnas Report	N.A	150 group leader	July 2012	150	Augustus 2012
GP 4.Peer group education for rover and senior ro	Increased knowledge&skills of immunization coverag	Kwarnas report	N.A	200	October 2012	200	November 2012
GP 5.Group operational (GUDEP)	Increased knowledge and skills of immunization cov	Kwarnas report	N.A	320	December 2012	400	Mar 2013
IBI 1.Baseline survey	Immunization and MCH services baseline data is ava	•Districts health office report • Qualitative stu	N.A	Completed	2010	100	Dec 2010
IBI 10.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	Flipchart 500 (100%)	N.A	500	N.A
IBI 11.Community Outreach	Community elucidation by midwives/nurses	IBI Report	N.A	50 in Bogor (2011), 580 in 4 district	2011-2012	930	2013
IBI 12.Community Outreach	Home visit elucidation by cadre	IBI Report	N.A	2500 (2011), 13250 (2012) 86%	2011-2012	18250	2013
IBI 13.Community Outreach	Socialization activities through meeting, progra	IBI Report	N.A	20 (2011), 53 (2012)	2011-2012	73	2013
IBI 14.Community Outreach	Agreement reached about the program comprehensio	IBI Report	N.A	365 villages	2011-2012	365	2013
IBI 15.Endline survey	Data on immunization coverage and MCH services ava	Districts health office report	Baseline data survey	Not yet	Not yet	100	July 2013
IBI 16.Endline survey	Data on immunization coverage and MCH services ava	Qualitative study	Baseline data survey	Not yet	Not yet	100	July 2013
IBI 17.Endline survey	Data on immunization coverage and MCH services ava	IBI	Baseline data survey	Not yet	Not yet	100	July 2013
IBI 2.Trainings	- ToT for midwives and nurses from provincial and	IBI Report	N.A	18 trainers	2011	18	2011
IBI 3.Trainings	- 365 midwives and nurses in regency level are tra	IBI Report	N.A	511 midwives and nurses	2011	365	2011
IBI 4.Trainings	- Cadre and accoucheuse training in sub district l	IBI Report	N.A	1375 Cadres	2011-2012	1875	2013

IBI 5.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	Pocket book 5000 (100%)	N.A	5000	N.A
IBI 6.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	Leaflet 22000 pcs	2011-2012	22000	N.A
IBI 7.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	Poster 2000 (100%)	N.A	2000	N.A
IBI 8.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	Pin 21000 pcs	2011-2012	21000	N.A
IBI 9.Dissemination of IEC	Development, production and dissemination of IEC m	IBI report	N.A	T-shirt 2700 pcs	2011-2012	2700	N.A
PKK 1.Developing 2 manuals on immunization progr	Manual production and reprinting	TP PKK report	N.A	Accomplished	2012	2	2012
PKK 2.Community outreach	1.Orientations for cadres	TP PKK report	N.A	On progress	2012	10	2013
PKK 3.Community outreach	2.Community outreach a. Group eludication by cadr	TP PKK report	N.A	On progress	2012	10	2013
PKK 4.Monitoring and Evaluation	Monev report	TP PKK report	N.A	4 Provinces	Dec 2012	4	2013

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.

* For table 10.2.5 :Because of some columns cannot be filled in accordance to the real report orcondition, we have attached the file titled " APR CSO 2012 Final" in the attachment section ("other" column) for detail information.

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 thereports submitted by CSO at the end of each financial term as well as supervisory activities and regular meetings thus develops monthly and quarterly reports.

HSCC/Secretariat/TechnicalTeam monitor the activities and results of CSOs in the project area through quarterly reports, supervision, team meetings and national meeting (midterm and end of project). Feedback will be delivered directly after the data was analyzed.

Themain activities which willbe monitored are:

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

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

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 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 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 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	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 2012	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 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 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 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	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 2012	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 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 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 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	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 2012	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 Minister of Health & Minister of Finance (or delegated authority).PDF File desc: Date/time: 5/15/2013 8:49:34 AM Size: 682301
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature of Minister of Health & Minister of Finance (or delegated authority).PDF File desc: Date/time: 5/15/2013 8:50:15 AM Size: 682301
3	Signatures of members of ICC	2.2	✓	HSCC Signatures.PDF File desc: Date/time: 5/15/2013 10:28:12 AM Size: 4564280
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✓	Minutes of Meeting HSCC May 14 , 2013.doc File desc: Date/time: 5/15/2013 10:22:07 AM Size: 56832
5	Signatures of members of HSCC	2.3	✗	HSCC Signatures.PDF File desc: Date/time: 5/15/2013 10:30:48 AM Size: 4564280
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✓	Minutes of Meeting HSCC May 14 , 2013.doc File desc: Date/time: 5/15/2013 10:22:56 AM Size: 56832
7	Financial statement for ISS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	Financial Statement ISS_2012 new.pdf File desc: Date/time: 5/15/2013 12:16:53 PM Size: 112958
8	External audit report for ISS grant (Fiscal Year 2012)	6.2.3	✗	Independent Audit _BPKP_Indonesian Version.pdf File desc: Date/time: 5/15/2013 12:17:41 PM Size: 734776
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM2_report-Indonesia-2012 v4.pdf File desc: Date/time: 5/5/2013 9:02:16 AM Size: 4641475

17	Valid cMYP if requesting extension of support	7.8	✗	cMYP- ENGLISH.doc File desc: Date/time: 5/15/2013 12:21:08 PM Size: 2312192
18	Valid cMYP costing tool if requesting extension of support	7.8	✓	cMYP_Costing_Tool.xls File desc: Date/time: 5/15/2013 12:22:14 PM Size: 3571200
19	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health.pdf File desc: Date/time: 5/15/2013 8:55:47 AM Size: 886342
20	Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health.pdf File desc: Date/time: 5/15/2013 8:55:48 AM Size: 443920
21	External audit report for HSS grant (Fiscal Year 2012)	9.1.3	✗	Independent Audit _BPKP_Indonesian Version.pdf File desc: Date/time: 5/15/2013 12:18:38 PM Size: 734776
22	HSS Health Sector review report	9.9.3	✗	Independent Audit _BPKP_Indonesian Version.pdf File desc: Date/time: 5/15/2013 1:43:23 PM Size: 795783
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	Laporan Mapping.doc File desc: Report for Mapping CSO Date/time: 5/15/2013 12:40:35 PM Size: 64512
24	Financial statement for CSO Type B grant (Fiscal year 2012)	10.2.4	✗	Financial Statement CSO4.jpg File desc: Financial Statement CSO Type B Date/time: 5/15/2013 12:53:51 PM Size: 186764
				Independent Audit _BPKP_Indonesian Version.pdf

25	External audit report for CSO Type B (Fiscal Year 2012)	10.2.4	✗	File desc: Date/time: 5/15/2013 12:19:39 PM Size: 734776
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2012 on (i) 1st January 2012 and (ii) 31st December 2012	0	✓	Dokumen Bank Statement March 2013.pdf File desc: Date/time: 5/15/2013 1:43:59 PM Size: 433194