

## Joint appraisal report

<b>Country</b>	Indonesia
<b>Reporting period</b>	<i>Month/Year of the last appraisal report – Month/Year of the current appraisal (May 2015)</i>
<b>cMYP period</b>	2015 – 2019
<b>Fiscal period</b>	<i>January – December</i>
<b>Graduation date</b>	<i>Only relevant for graduating countries (2012)</i>

### 1. EXECUTIVE SUMMARY

#### 1.1. Gavi grant portfolio overview

##### 1.1. Gavi grant portfolio overview

The Government of Indonesia has received GAVI grants since 2002 for increasing immunization coverage through NVS for Hep.B Mono (2002 – 2008), INS (2002 – 2005), ISS (2003 – 2007), CSO Type A (2008), CSO Type B (2008 – 2011), HSS (2008-2014).

From 2013-15, funding was provided for pentavalent vaccine and VIG IPV (2015 – 2017). Total grants already approved is \$ 127,484,000. GAVI grants are implemented in all 33 provinces.

Based on JRF data, 2014 coverage was DPT1 (94%), DPT3 (92%), and MCV1 (91%). Hep-B birth dose coverage has increased and successfully achieved the target of  $\geq 80\%$  coverage.

Based on administrative data for routine immunization report, DPT3 coverage is 95% (consists of DPTHB3 49.7% and DPTHBHib3 45.7 %.) This happens because 30 out of 34 total provinces began to implement Pentavalent vaccine introduction in 2014. (target is 90%), Polio3 coverage is 95.5% (target: 90%), and MCV1 coverage is 94,7% (target: 90%). The overall coverage indicates that effort to reach targeted children is optimal.

##### Health System Strengthening (HSS)

Total GAVI HSS grant to Indonesia is \$ 24.8 million. The final tranche of US\$ 9.4 m has been disbursed. The three objectives for 2015-2016 are (1) improve DPT3 Immunisation coverage in low coverage areas; (2) capacity development on ensuring data collection and reporting (3) improving the competency of Immunisation staff by strengthening implementation of MCH-Immunisation materials for Midwifery institutions. Both Gavi and government funds go towards supporting these activities down to health center level.

##### Pentavalent Introduction

The pentavalent vaccine was introduced in August 2013 into four provinces and by early 2015, had been successfully rolled out in all of the remaining 29 provinces. Approval is requested for the final tranche of US\$ 6,855,500 for 2016 for self-procurement of 5 dose vials from national vaccine manufacturer BioFarma, but these funds will only be disbursed after a cash audit of the programme. Co-financing commitments for 2013 and 2014 have been fulfilled.

### Indonesia Delays IPV Introduction until July 2016

Indonesia being a very large country with geographical challenges requires additional time for introduction of any new vaccine. The delay was confirmed in a June 2015 letter from the MoH to Gavi's CEO. The following is the new 2016 timeline:

- a. To mitigate of risk transmission type 2 and to increase immunity from all three types before switch tOPV to bOPV, the country plans to conduct national polio campaign for 0 – 59 month in February 2016
- b. Conduct switch tOPV to bOPV on April 2016 and then tOPV withdrawal from all health facilities and determine of National laboratory for Polio to keep P2 after switch tOPV to bOPV
- c. Conduct IPV introduction on July 2016 (by which time the vaccine produced by Biofarma should be ready to use)
- d. Encourage Biofarma to finalize license or market authorization of bOPV quickly and accelerate IPV production.

### Summary of grant performance, challenges and key recommendations

#### Programmatic Achievements with Gavi Funds

- Successful Pentavalent introduction in all 33 provinces
- Increasing immunization coverage especially DPT-HB3 / DPT-HB-Hib3 in 134 district/city with low immunization coverage area through innovative activities (Drop Out Follow Up – DOFU Immunization, SOS strategy)
- Implementation of Data Quality Self assessment (DQS) in 166 Districts/city
- Improving capacity of immunization and MCH staffs, trained 86.789 cadres
- Strengthening through empowerment community to increase demand of immunization through Civil Society Organization → involving Midwives Indonesian Organization, Scout Movement, PKK, religious leader and community leader
- Developed infrastructure of integrated Recording and Reporting of Immunization at health center in 6 provinces
- Advocacy and Socialization of new vaccine introduction involving experts, CSO, religious leaders and community leaders in 6 provinces (GAVI fund) and 27 province (GoI)
- Increasing capacity for health workers in order new vaccine introduction in 6 provinces (GAVI fund) and 27 province (GoI)
- Immunization forum in order to overcome the negative issues of immunization

#### Financial Management

A Cash Programme Audit (CPA) for 2008-2012 HSS, CSO Type B and NVS for self-procurement carried out in early 2013 found no evidence of financial irregularities and concluded that the Ministry of Health had put in place the majority of control procedures outlined in the Aide-memoire resulting from GAVI's Financial Management Assessment. In future, audit reports will be communicated in English (official translated version). Annual audit from Board of Supervisors Finance and Development (BPKP). The Partnership Framework Agreement was signed in December 2014. Treasuries are being formed at provincial level to coordinate financial reports from district.

#### Challenges

- Immunization coverage discrepancies in pockets within provinces and districts and risk for VPD outbreak (measles and VPD outbreaks still occur suggesting population immunity gaps despite high reported administrative coverage)

<ul style="list-style-type: none"> <li>• Discrepancies between administrative data and coverage survey</li> <li>• Many Hard to reach areas which need to be covered through SOS activities</li> <li>• Drop out of immunization due to low of awareness about benefits as well as insufficient systematic tracking and follow up in some areas</li> <li>• Limited number and capacity of staff at national and provincial level to conduct the planned intensive monitoring, technical assistance and follow up action, based on results of coverage survey at 31 districts in 10 provinces. Staff turnover a problem.</li> <li>• Cold chain inventory conducted in 2014 found functional status of cold chain equipment at all levels there are 871 (18%) not working, 612 (12%) working but need attention and 3.483 (70%) functional.</li> <li>• Limited allocated operational budget for immunization program at local government in some areas</li> <li>• Lack of knowledge at health workers about immunization program and turn over immunization staff</li> <li>• Strengthening required for accurate and robust data systems (immunization services and surveillance)</li> </ul>
<p><b>Key recommended actions to achieve sustained coverage and equity</b> (list the most important 3-5 actions)</p>
<ol style="list-style-type: none"> <li>1. Conduct drop out follow up (DOFU) and sweeping at 31 districts in 10 provinces with low coverage/large numbers of un-immunized children based on baseline profile (after coverage surveys in each district)</li> <li>2. Reach the un-immunized children whose live at the hard to reach area using SOS strategy</li> <li>3. Communication forum (communication support group friends from immunization ) and develop demand generation based on research, partnership with Local Government, NGOs and others</li> <li>4. Recruitment monitors (temporary contract) to conduct intensive monitoring, technical assistance and follow up action base on results of coverage survey at 31 districts in 10 provinces.</li> <li>5. Cold Chain Improvement (EVM assessment, inventory cold chain and procurement)</li> <li>6. Facilitation to Increase Immunization Coverage and Immunization Service by collaborating with Health Education Institution</li> </ol>

## 1.2. Requests to Gavi's High Level Review Panel

<p><b>New and underused vaccine support</b> Pentavalent final tranche, US\$ 6,855,500, for self-procurement of 5 dose vials from BioFarma</p> <p><b>Health Systems Strengthening Support</b> HSS1 2008-2015 funds of US\$ 24.8m are fully disbursed. No requests for re-allocation or reprogramming.</p>
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## 1.3. Brief description of joint appraisal process

Reports related to finance and the audit report by the Board of Supervisors Finance and Development (BPKP) were collated. BPKP is the government auditor. The Joint appraisal was done through a consultative process involving the SCM, all in country partners and relevant programs, looking in depth at current issues and challenges of EPI/HSS program. Draft JA was submitted to GAVI formally and circulated within the Secretariat for comments. Final draft was prepared in country and submitted to HSCC for approval.

## 2. COUNTRY CONTEXT

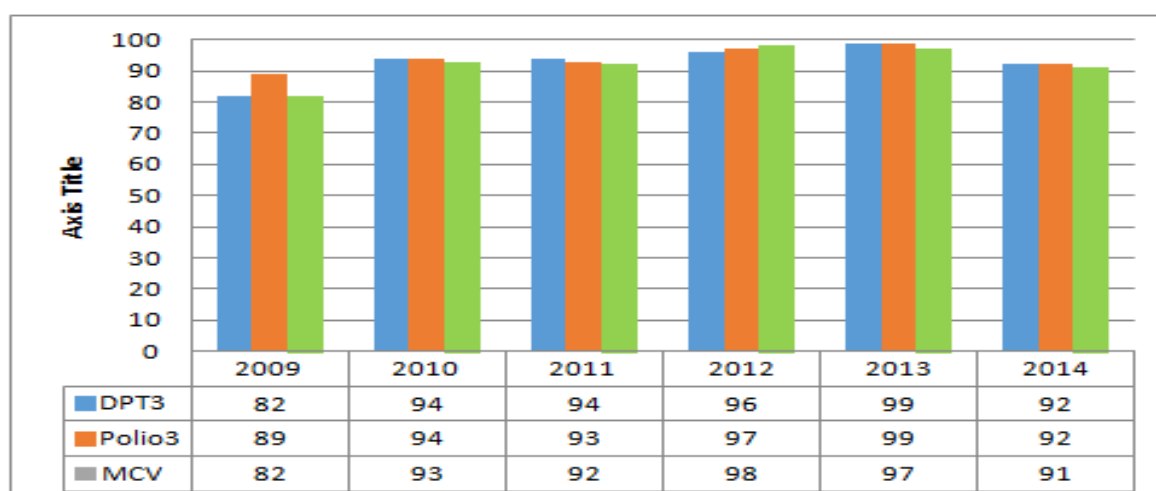
### Background

Indonesia is the 4th biggest country in the world with total population of 253 million in 2015, distributed in 33 provinces. Geographically the country consists of around 17,000 islands. Each year, about 5 million babies are born and all need to be protected by immunization. Indonesia's national childhood Immunization Program has for many years reported overall immunization coverage rates of 80% or higher for all Expanded Program on Immunization (EPI) antigens; however, these figures continue to mask pockets of lower performance in some areas. Some of these areas are in large urban areas, some are generally remote, inaccessible areas, where means of access are limited, terrain is difficult and populations are small and dispersed. As a result, service delivery is often difficult, time consuming and expensive to provide or sustain on a regular basis and infants and children do not have access to the levels of health care provided in other parts of the country.

The achievement of immunization coverage in Indonesia has shown good performance but inequities still exist geographically, by wealth classification, urban and rural and mothers' education. Challenges include quality of immunization services, safe injection practices and waste disposal management.

The coverage of DTP3, Polio3 and MCV in 2014 have reached their targets target and the trend since 2009 is increasing. The graph shows that DTP3 coverage is 92% (target: 90%), Polio3 is 92% (target: 90%), and MCV is 91% (target: 90%). The overall coverage indicates that effort to reach targeted children is optimal.

**Graph. Coverage of DTP3, Polio3 and MCV 1**



Source: WHO/UNICEF Joint Reporting Form on Immunization

In 2014, DTP3 coverage decreased due to Auto Disable Syringes (ADS) not being available at Health Center facilities due to procurement delays.

Indonesia has 509 districts in 33 provinces. In 2014, there are 72% districts with DTP3 coverage >80% and only 40% districts with MCV coverage  $\geq$  95%. It shows that variance among district for MCV coverage is high. It needs extra effort from Central Government to push the performance of districts and allocate resources to intervention the districts with low coverage.

Indicator	2009	2010	2011	2012	2013	2014
Number of districts with DTP3 coverage $\geq$ 80%	382	389	397	392	412	366
Percentage of districts with DTP3 coverage $\geq$ 80%	80	79	80	79	82	72
Number of districts with MCV coverage $\geq$ 95%	162	197	198	269	226	204
Percentage of districts with MCV coverage $\geq$ 95%	34	40	40	54	45	40

### Management of Health Delivery in a Partially Decentralized System

The central government is responsible to develop guidelines and standards, procurement of vaccines and syringes, monitoring and evaluation, quality control and capacity building through training and management of health human resources for public health. Ensuring sustainability of availability resources to support immunization program activities such as supplementary immunization activities, procurement of vaccines and syringes, technical assistance, is also part of the central government's responsibility.

The local governments support the implementation in their area, provides budget for human resource recruitment and management, incentives, transportation, operational and maintenance. Primary Health Center (PHC) provides services to the community, guided by the District Health Office.

### Costing and Financing <sup>1</sup>

Because of partial decentralization, the financial management system is complex, which impedes timeliness and predictability of resources at the lowest levels where service delivery funding is regularly required to reach all children. Fiscal capacity of the districts varies. For districts with low fiscal capacity sufficient funding to ensure achievement of the target remains challenge.

Economic growth continues to be significant, with IMF projecting 6.5% per year from 2013 to 2018 and the country's GNI has steadily risen from \$570 in 2000 to \$3,420 in 2012, in 2011 however, the government spent only 6.2% of its budget on health, and in 2012 6.9% - a relatively low allocation which is even below the national constitutional target.

Another factor impacting sustainability is that the government has launched universal health care with expected full coverage by 2019. How this will affect immunization funding and EPI performance post 2016 is uncertain, but there is a possibility that preventive services may be crowded out by new financial demands and patient pressure for new curative services.

<sup>1</sup> For cMYP 2015-2019 Objectives, please refer to Annex E

These uncertainties should be weighed against Indonesia's well-established track record of self-financing and reliable domestic vaccine production, and the fact that GAVI's funding has been relatively small over a 10 year time frame, and highly catalytic.

In 2014, Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US\$, was as follows :

Expenditure by category	Expenditure Year 2014	Source of funding			
		Country	GAVI	UNICEF	WHO
Traditional Vaccines*	24.723.358	24.723.358	-	-	-
New and underused Vaccines**	23.660.582	13.163.117	10.497.465	-	-
Injection supplies (both AD syringes and syringes other than ADs)	8.153.831	6.816.112	1.337.719	-	-
Cold Chain equipment	1.909.943	1.909.943	-	-	-
Personnel	23.758.770	23.540.000	218.770	-	-
Other routine recurrent costs	46.164	46.164	-	-	-
Others Capital Costs	72.498.635	69.974.503	2.225.509	281.000	17.623
<b>Total Expenditures for Immunisation</b>	<b>154.751.283</b>	<b>140.173.197</b>	<b>14.279.463</b>	<b>281.000</b>	<b>17.623</b>
<b>Total Government Health</b>					

### 3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

#### 3.1.1. Grant performance and challenges

##### Accelerated Pentavalent Roll Out

In 2014, Indonesia delivered pentavalent vaccine to 31 provinces, and in early 2015 national rollout was completed by introducing in the remaining 2 provinces Aceh and NTT.

Introduction went smoothly with high coverage and no serious AEFI cases, anti-vaccine lobby was effectively & proactively addressed by engaging all sections of society, NGO, CSO and local leaders and use of effective communication strategies.

Co-financing obligations are being met and are able to be tracked in detail from BioFarma purchase orders, which are regularly provided to the Secretariat by the EPI Manager. Co-financing receipts submitted in December 2014 and audited during a Gavi and partners country visit in March 2015 confirm that Indonesia fulfilled its 2014 requirements.

No.	Item	Year 2013				Year 2014			
		Required Co		Purchased		Required Co		Purchased	
		GAVI	Country	GAVI	Country	GAVI	Country	GAVI	Country
1	Pentavalent Vaccine doses	3.688.100	917.100	7.081.205	1.963.045	13.415.500	6.607.700	10.002.395	16.718.195
2	ADS 0,5 mL pc	3.263.400	815.900	5.411.611	6.048.940	11.800.000	5.812.000	9.651.789	1.781.341
3	Safety Box 2,5 Lt pc	36.225	9.075	60.067	150.400	131.000	64.525	107.158	140.667

##### Data Quality

Data quality is a longstanding concern in Indonesia. The established system for coverage and disease reporting uses varied denominators, leading to inflated coverage estimates. In addition, coverage data at lower levels is unreliable because of poor data entry at the posyandu, with data not recorded after each immunization but at the end of each session, and sometimes not at all. In addition, DQS reveals data accuracy problems between posyandu and health centers, with over-reporting. Retention of immunization cards is less than 50%.

Regular house-hold surveys to validate coverage are conducted, but they lack standardization in survey methods, and there is large variation in coverage estimates between administrative data and surveys and between surveys themselves. In 2011, there was a >20% discrepancy (84% versus 63%) between administrative and WHO/UNICEF DPT3 estimates.

Improvement of coverage data improvement activities and active surveillance systems for vaccine preventable diseases are planned but their implementation is lagging.

### **Activities to Strengthen Data Management**

In 2014 HSS Grant activities included implementation of DQs in 62 districts (by Gavi budget) and 104 districts (by Country Budget).

- To improve data collection and reporting quality, DQS activities have been replaced with DQAs
- Individual web based recording introduced in 10 provinces after independent assessment
- Vactrax
- RapidPRO at slum and urban area supported by UNICEF (Jakarta )
- District coverage survey

### **Vaccine and Cold Chain Management Issues**

Indonesia already minimalizes delayed procurement through e catalogue system. The e – catalogue system can shorten procurement process. Procurement of cold chain based on results of inventory cold chain and data collection 2014. Established SMS System for cold chain temperature monitoring.

### **Activities to strengthen stock management and cold chain management:**

#### **a. Effective Vaccine Management (EVM)**

In 2011 – 2012, Indonesia already conducted EVM Assesment at 39 sites (yr 2011) and 54 sites (yr 2012) and monitored improvement plan.

For 2015, expected EVM Assesment will be conducted at 69 sites and improvement plan activities from GAVI Support through HSS Reprogramming.

#### **b. Cold Chain Inventory and Data Collection**

In 2014, Indonesia already conducted cold chain inventory and Data Collection in 19 provinces and 15 provinces remaining will be conducted in 2015 through HSS Reprogramming

### **Service Delivery**

Primary health care services, including immunization, are delivered by Integrated Service Posts (Posyandu). The Posyandu system has generally performed well since its introduction in the mid-1980s, although there are weaknesses in supervision and accountability for efficient delivery of

immunization services. There is also a brief window available for immunization of children at Posyandus, generally a half day per month, which is often announced at short notice.

BioFarma production site acts as the National cold store and supplies the 34 provinces directly. The EVM assessment (yr 2012) concludes that BioFarma performance is strong, with solid and reliable support for vaccine cold chain logistics. Vaccine distribution under the responsibility of provinces and districts is weaker. The overall system generally ensures adequate supplies of vaccines and syringes at all levels, though delays in the contracting process have occasionally led to stock-out of vaccines in some provinces in the early part of the year. At district and health center level, much of the cold chain equipment requires replacement. A cold chain inventory and replacement plan is underway.

### **Demand generation and communication**

One of the most challenging obstacles is negative campaigns. The issues regarding this campaign are the issues about halal and haram, issue that breast feeding can replace immunization and issue that vaccines which are being used in Indonesia are western products while in the reality is all vaccines used in our program are produce by BioFarma, the national vaccine manufacturer.

Other challenge is about AEFIs cases, for example rumors in media, negative publicity, and unmanaged AEFI cases that will lead to rejection from parents. In addition, other evidence based barriers to complete the required doses are: lack of understanding of parents on the need of 5 visits to enable their children to be fully immunized; lack of messages and reminders to mothers/caregivers immediately following vaccinations on how to manage fever side effect at home and dates when to return; and insufficient religious leaders positive support to community members on immunization.

In 2015-16, an immunization communication strategy will be conducted at 3 provinces and will be expanded to 31 districts in 10 provinces supported by Gavi after district coverage surveys in those areas. Health worker training in interpersonal communication partnering with local leadership, MCH and Immunization cadress and Civil Society Organization (CSO). IEC material for routine and new vaccine will be developed in collaboration with health promotion, UNICEF, WHO and CSO. This training activities will be conducted in 5 provinces and 62 districts

- Public Service Announment (PSA) – media electronic, social media, etc

- WIW every April at national and province level

- SMS activity in collaboration with MCH program

- Communication forum on immunization in collaboration with BioFarma, Pediatrician association and MUI (Indonesia Moslem Council)

- Collaboration with Mass Media, TV, Local Radio , and other media (Fb, Twitter)

- Immunization Certificate for children who already receive complete basic immunization

These tailored messages and materials with targeted audiences will still require massive roll out all over the country.

### **Overall programmatic capacity of entity managing NVS grants**

Reasonably good programmatic capacity if consider the EPI programme capacity combined with BioFarma's vaccine manufacturing efficiency and reliable logistic system for supply chain.



**Financial performance and challenges:**

Please refer to Section below on New Strategic Focus of HSS1 Grant

**NVS renewal request / Future plans and priorities****New and underused vaccine support**

Pentavalent final tranche, US\$ 6,855,500, for self-procurement of 5 dose vials from BioFarma

**Health systems strengthening (HSS) support (Grant performance and challenges)****HSS Programmatic performance and challenges:**

In 2014, to improve and sustain coverage and equity in access to immunisation, the HSS strategy was as follows :

Reduce the drop out rate by performing DOFU in areas with low immunization coverage, targeting 0-11 month old babies and 12-36 month old babies in 60 districts/cities of 18 provinces who have not received complete basic immunization.

Increase number of children receiving complete immunization by conducting SOS immunization activities conducted in 11 Provinces, 33 District or cities, 166 health centers and 283 villages. Through this SOS strategy, 5.591 of babies received complete immunization (target 6,377 babies)

Demand generation by increase awareness on immunization. Piloted in 3 districts (3 provinces) Kab. Lahat (South Sumatra), Bandung (West Java) and Gowa (South Sulawesi). Test results showed radio listening to be high, so and MCH and Immunization Broadcasting Jingle was developed and broadcast in 11 provinces.

Strengthening of Reporting and Recording through integrated individual registration system (implementation of web-basedRR).

Develop of Curriculum of MCH and Immunization for health education Institutions

**Challenges**

- Low pockets of immunization coverage in some province and district risks VPD outbreak,
- Indonesia has some hard to reach areas and these areas will be covered through SOS activity integrated with other related program
- Drop out of immunization due to low of awareness about benefit of completing the required number of immunization visits, in country migration of families; no regular and systematic tracking; low window ( half day per month) of immunization opportunity in posyandu
- limitation of staff at national and provincial level (number and capability) to conduct intensive monitoring, technical assistance and follow up action, base on results of coverage survey at 31 districts in 10 provinces so we need additional monitor to fill the gap
- Based on partial results of cold chain equipment inventory conducted in 2014 found functional status of cold chain equipment, all levels there are 983 (16%) not working, 831 (13%) working but need attention and 4355 (71%) functional.

- Limited allocated operational budget for immunization program at local government in some areas as well as fund flow delays impacting core immunization activities such as conduct of mobile outreach services, repair, procurement and maintenance of cold chain equipment, vaccine distributions and social mobilization
- discrepancies within administrative data and coverage survey
- lack of knowledge at health workers about immunization program and turn over immunization staff
- limitation of staff at national and provincial level (number and capability) to conduct intensive monitoring, technical assistance on program specific expertise and follow up action, base on results of coverage survey at 31 districts in 10 provinces so we need additional monitors and subject matter experts to fill the gap

### **New Strategic Focus of HSS grant for 2015-16**

Implementation of the US\$ 24.8 million 2008-09 HSS grant has been problematic and there have been substantial delays. This underperforming grant became stalled in a cycle of delayed submission of APRs and resulting late disbursement of funds.

Between January 2014 and May 2015, much work by the Gavi and EPI teams at the Ministry of Health, in consultation with WHO and UNICEF, went into revising the activities in the HSS work plan (US\$ 9.4 million) to make them more effective. The HSCC agreed to a plan for 2015-16 to focus on 31 districts with low coverage and high childhood mortality. These districts contain almost 20% of the annual birth cohort of 4.6 million, and most of these are in densely populated urban poor areas. As mentioned in the Data Quality Section above, baseline coverage surveys in all 31 districts will provide much-needed concrete objective information on where coverage is lower than desired and hopefully why.

In recognition of the low coverage in some remote eastern areas, there are some proposed activities beyond the 31 focus districts such as the DOFU implementation, RR implementation and the SOS implementation in remote areas (25 districts). Focusing on problem districts for most of the activities is more realistic and likely to result in real improvements rather than spreading the activities out more broadly, and the baseline surveys will also make monitoring and evaluation more feasible.

This re-focusing of the programme's activities went some way to putting Indonesia's HSS programme back on track and unblocked disbursement of the final tranche of HSS funding of US\$ 9.4 million that was recommended for approval by the IRC in October 2013, reviewed after the Gavi visit in March 2015 and disbursed in July 2015.

An HSS1 end of grant assessment is budgeted and planned for 2016.

### **Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans**

No request

### **Graduation plan implementation**

Graduation mission to be undertaken in late 2015 or early 2016
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### 3.1. Financial management of all cash grants

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| <ul style="list-style-type: none"> <li>• No major issues arising from Cash Programme Audit</li> <li>• No modifications made to financial management arrangements</li> <li>• GAVI funds are recorded in the state budget (DIPA)</li> <li>• Further disbursements of GAVI cash grants to provincial health offices uses bank accounts in the name of MoH via electronic transfers to banks at provincial and district level</li> <li>• the Independent audit of all GAVI supported programmes for the current financial year and any future financial years has been undertaken by BPKP</li> </ul> |
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### 3.2. Recommended actions

Please refer section above 'Key recommended actions to achieve sustained coverage and equity.'

## 4. TECHNICAL ASSISTANCE

### 4.1 Current areas of activities and agency responsibilities

<p>Presently WHO and UNICEF staff provide technical assistance to EPI program through their offices based at Jakarta, WHO is more focused on policy, strengthening of monitoring , generating evidence, data quality, supporting VPD surveillance. UNICEF supports strengthening supply chain system (cold chain, EVM), Communication, evidence based demand generation and equity focused Reaching Every Community approach, Innovations and Real time monitoring, and decentralized planning, and budgeting.</p>
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### 4.2 Future needs

#### Technical Assistance needed:

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| <ul style="list-style-type: none"> <li>• Improve demand generation for immunization and develop of strategy communication to anticipate of negative issue and other existing barriers</li> <li>• Develop and pilot strategies for strengthening immunization in migrant populations</li> <li>• Strengthening Immunization systems to reach the unreached or partially reached to narrow equity gaps both in urban and remote areas.</li> <li>• Conduct social research to improve the delivery of immunization services and the ability to meet the needs of diverse communities.</li> <li>• Strengthening Immunization Supply Chain System ( Cold Chain, Vaccine Management, Information System)</li> </ul> |
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**Capacity Building needed:**

- Strengthen national capacity to formulate evidence-based policies for introduction of new and underutilised vaccines
- Enhance knowledge and capacity of sub national and district level EPI managers
- Robust real time web based data collection and analysis
- Potential partners to provide support : WHO is requested to assist

Short term support (6 months) is needed specifically at sub national level for technical assistance, deployment of regional level managers/ monitors for smooth tOPV to bOPV switch and IPV introduction. Medium term support needed to strengthen VPD surveillance including strengthen national and sub national Laboratory diagnostic capacity for VPDs to generate rubella disease burden specifically enhance measles case based surveillance, CRS Surveillance which will help to facilitate Rubella vaccine introduction and support for other diseases like JE, dengue, influenza. Support to improve data quality and socio-economic equity in immunisation coverage through supporting independent coverage survey, and building DQA capacity at sub national level.

**ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS**

Joint appraisal was endorsed by the relevant national coordination mechanism: draft was circulated among all concerned for feedback/ comment. Joint appraisal was endorsed through HSCC Meeting that attended member of HSCC (including inter – agency and CSO) in the same time with the APR GAVI in May 2015

Issues raised during debrief of joint appraisal findings to national coordination mechanism:  
None

Any additional comments from

- Ministry of Health: none
- Partners: none
- Gavi Senior Country Manager: Feedback Email from Gavi Secretariat to MoH on First Draft of JA

Dear All,

Please find further comments on the draft Joint Appraisal from my Gavi colleague Laura Crow. These are important, and please take them into account as you finalize the Joint Appraisal. One of the weaknesses of the current draft is that there are many lists of objectives and activities but very little comment about results/achievements.

Many thanks  
Andrew

**ANNEXES**

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)
- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
<b>PFA</b> Request the Minister of Health to address the delay in the PFA signing.	Done. PFA signed in December 2014
<b>Data Quality</b> Follow up on planning for district level DQs that are included in the HSS Grant's 2015 activities	Done. 31 districts agreed on for DQAs in 2015

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)

Team composition (representative from EPI, MCH, Unicef and WHO)

Data and information in this Joint Appraisal has been suggestion from stakeholders who participated in the process. Source of Data and information from JRF and national immunization data (administrative data)

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date		14 August 2008					
1.2 Date of reprogramming approved by IRC, if any		8 December 2011					
1.3 Total grant amount (US\$)		\$ 24.827.500					
1.4 Grant duration		2008-2014 (Originally approved 2008-2010)					
1.5 Implementation year		month/year – month/year					
(US\$ in million)	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
1.6 Grant approved as per Decision Letter	7.960.852	16.866.397					
1.7 Disbursement of tranches		270,000			3,723,000	3,723,000	
1.8 Annual expenditure		333,304	3,729,715	1,537,530	2,445,816	1,812,583	2.339.049
1.9 Delays in implementation (yes/no), with reasons							

1.10 Previous HSS grants (duration and amount approved)	Originally approved 2008-2010, amount approved \$ 24.827.500
<p>1.10.1 List HSS grant objectives</p> <ul style="list-style-type: none"> <li>- Before Reprogramming</li> </ul> <p>Improved coverage of maternal and child health services, including immunization, through :</p> <ol style="list-style-type: none"> <li>1. Community Mobilization</li> <li>2. Capacity building of MCH program management at district and health center level</li> <li>3. Partnership with CSOs</li> <li>4. Pilot Project on contractual relationships and incentive mechanism</li> </ol> <ul style="list-style-type: none"> <li>- Objective of Reprogramming</li> </ul> <p>Reprogramming aimed at acceleration on the achievement of DPT3 immunization coverage with emphasis on;</p> <p>GAVI HSS will continue to support the following project components/objectives as follows :</p> <ul style="list-style-type: none"> <li>Improve immunization coverage in low coverage areas</li> <li>Capacity Development on ensuring data collection and reporting</li> <li>Improve immunization staff competency through strengthening implementation of MCH-Immunization material for public health institution</li> </ul>	

- **Annex E. cMYP 2015-2019 Objectives**

According to the comprehensive Multi Year Plan (cMYP) 2015-2019, our main objectives and priority actions are:

2015

- To achieve 91% completely basic immunization
- To maintain MNTE in three regionals
- 100% number of provinces meeting certification level surveillance standards
- At least 5 number of sentinel sites fully implementing surveillance for CRS
- 80% of districts with timely & complete reporting (including zero reporting) of NT
- Sustain polio free status

2016

By 2016, establish a national policy on vaccination across the life-course : Develop a national policy for immunization across the life-course and prioritise vaccines for inclusion

- To achieve 91,5% complete basic immunization
- All Provinces have conducted Polio campaign with coverage > 95%
- To mitigate risk and protect children, EPI program will undertake crash program with measles vaccine from 2015 until MR Campaign, based on local epidemiology
- Achieve MNTE in the remaining region in 2016
- 2016: Immunization data collection tools and methods standardized across all household surveys
- Introduction one dose of IPV
- Switching tOPV to bOPV (all provinces)

- Withdrawal tOPV from all health services
- **Annex F. HSS Activities Implemented in 2014**

**Objective 1 Area with low immunization coverage through acceleration of immunization coverage in low coverage areas**

Through Mid-term review meeting on Immunization and NMCH Coverage - identify district low coverage and identify villages with low coverage area using LAM results existing problems in order to support the planning area in 2015

Drop Out Follow up Immunization conducted in the 60 districts in the 18 provinces

The SOS strategy, the expected access to basic health services for children and mothers can be improved through an integrated immunization and MCH with a minimum frequency of visit 3-4 times a year.

Improving competence and skills of health workers in the management of neonatal and immunization. Papua and West Papua have special conditions area, so it requires a special approach with a more simple way to improve the skills of health workers, especially midwives and nurses

Increasing demand immunization through IEC, communication strategy, using jingle MCH and Immunization and implementation at health center

District level training of cadres on basic immunization and maternal and child health practices  
Cadres Training

For Cold Chain improvement, conducted capacity training of immunization staff in sub national level in order to handle cold chain and maintain quality of vaccine (vaccine management)

**Objective 2 Capacity Development on ensuring data collection and reporting**

- a. Creating an integrated MCH and Immunization recording and reporting system. The simplified variables have been the result of format review by considering data availability on the field, level of data priority for program stakeholders at central level, and minimizing duplication of data recording and reporting.
- b. Refreshing training and implementation of DQS at the full of the 7 provinces and 62 districts to get validate data immunization coverage from center until village

**Objective 3 Improve immunization staff competency through strengthening implementation of MCH-Immunization material for midwife institution (health education institutions)**

- a. Management training for immunization program for 239 hospitals in 3 Provinces including post training monitoring and evaluation
- b. Review & revise the immunization and MCH material in the midwife academic curriculum & introduce in the 51 health education institution in 5 Provinces

Remaining funds will be used to improve immunization coverage through the following activities:

1. Advocacy and Socialization of New Vaccine Introduction in selected provinces, districts and health centres involving religious leaders, community leaders and local NGO
2. Re print IEC of New Vaccine Introduction and distribute to all province (we plan to reallocate part of AEFI Socialization Meeting budget from VIG Pentavalent)
3. Increasing technical and managerial capacities of immunization officer at province, districts and health centre
4. Monitoring and assistance of the AEFI in order introduction of new vaccine and surveillance of the AEFI for new vaccine
5. Joint activities with independent organization to conduct post introduction evaluation (PIE) of pentavalent vaccine in 4 provinces