Joint Appraisal report 2017

The Italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal report.

Country	Indonesia
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	16-19 January 2018 | Jakarta, Indonesia
Participants / affiliation[1]	Please refer to Annex B
Reporting period	2017
Fiscal period[2]	January - December
Comprehensive Multi Year Plan (cMYP) duration	2015 – 2019

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

As part of the ongoing grant cycle, Gavi reviews and renews its support to the country annually (referred to as "renewal"). If a country's new and underused vaccine support (NVS) is coming to an end and the country is still eligible for Gavi support, it may submit a request to extend the support (referred to as "extension").

Below tables 1.1 to 1.4 will be pre-populated by the Gavi Secretariat based on the country information submitted through the Country Portal on 15 May and four weeks before the Joint Appraisal meeting. If there are any changes to be made, these changes should be discussed during the Joint Appraisal and flagged in the Joint Appraisal report.

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

1.2. New and Underused Vaccines Support (NVS) extension request(s)

If 2017 is the last year of an approved multiyear support for a certain vaccine and the country wishes to extend Gavi support, please do so by requesting an extension of the vaccine support. The extension can be requested maximum for the duration of the Comprehensive Multi-Year Plan (cMYP), which must be submitted to Gavi.

Type of Support	Vaccine	Starting year	Ending year
NVS - Vaccine	Measles Rubella	2017	2018
NVS – Vaccine	JE	2017	2018

1.3. Health System Strengthening (HSS) renewal request

Gavi commits to Health System Strengthening grants up to a five year period, with the first tranche approved with the approval of the proposal. In subsequent years, the country should submit a renewal request for the approval of the following HSS funding tranche.

Below table summarises key information concerning the amount requested for the next year. Please note that funds previously requested and approved may be pending disbursement and do ***not*** *require further approval.*

Total amount of HSS grant	US$
Duration of HSS grant (from…to…)	

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

Year / period for which the HSS renewal (next tranche) is requested	
Amount of HSS renewal request (next tranche)	US$

Not applicable. The HSS grant in Indonesia ended in July 2017.

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Similar to the Gavi HSS support, the Cold Chain Equipment Optimisation Platform provides phased support for a maximum duration of five years, which is subject to an annual renewal decision.

Below table summarises key information concerning the amount requested for the next year.

Total amount of CCEOP grant	US$	
Duration of CCEOP grant (from…to…)		
Year / period for which the CCEOP renewal (next tranche) is requested		
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$
	Partner resources	US$
	Gavi HSS resources[3]	US$

Not applicable

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.

[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

Background

*Gavi's support to a country's immunisation programme(s) is subject to an **annual performance assessment**. The Joint Appraisal is a key element of this performance review. It is an annual, country-led, multi-stakeholder review of the implementation progress and performance of Gavi's support to the country, and its contribution to improved immunisation outcomes.*

*To inform the Joint Appraisal discussion, the country is expected to post all reporting documents on the Gavi Country portal not later than **four weeks ahead of the Joint Appraisal meeting**.*

*This includes reporting against **key requirements**:*

- *Update of the grant performance framework (GPF) for indicators which are due*
- *Periodic financial reports, annual financial statements and audit reports (for all types of direct financial support received. with specific submission deadlines depending on a country's fiscal year)*
- *End of year stock reporting (which is compulsory to be submitted by 15 May of each year to calculate future vaccine requirements)*

Other critical information to be posted on the Country Portal four weeks prior to the Joint Appraisal include:

- *Immunisation financing and expenditure information*
- *Data quality information (including annual desk review and progress report on the implementation of immunisation data quality improvement plans)*
- *Annual progress update on the Effective Vaccine Management (EVM) improvement plan*
- *Campaign reports (if applicable)*
- *HPV specific reporting (if applicable)*
- *HSS end of grant evaluation (if applicable)*
- *Post Introduction Evaluation (PIE) reports (if applicable)*
- *Expanded Programme on Immunization (EPI) reviews (if applicable)*
- *Gavi and/or polio transition plans or asset mapping information (if applicable)*

Other information that will inform the Joint Appraisal discussion include:

- *Report by WHO and UNICEF on their technical assistance milestones funded through the Partners' Engagement Framework that should be updated four weeks in advance of the Joint Appraisal*
- *Analysis on coverage and equity and other relevant programme aspects, as informed by the Joint Appraisal Analysis Guidance (if available)*
- *Full Country Evaluation report (if applicable)*
- *Other evaluation of Gavi programmes*

Note: Failure to submit the relevant information described above on the country portal four weeks ahead of the Joint Appraisal meeting (except for the vaccine renewal request, which is to be submitted by 15 May) may impact the decision by Gavi to conduct the Joint Appraisal meeting and renew its support.

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Comment on changes which occurred since the previous Joint Appraisal, if any, to key contextual factors that directly affect the performance of the immunisation system and Gavi grants (such as natural disaster, political instability, displaced populations, inaccessible regions, etc., or macroeconomic trends or disease outbreaks).

Please indicate if the country has been formally identified by Gavi as fragile and specify if flexibilities in grant management are being requested.[5]

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

This section should provide a succinct analysis of the performance of the immunisation system, including a thorough analysis of immunisation coverage and equity, as well as a review of key drivers of poor coverage. It should focus on the evolution/trends observed over the past two to three years and particularly changes since the last Joint Appraisal took place.

Information in this section will substantially draw from the recommended analysis on coverage and equity and other relevant programme aspects which can be found in the Joint Appraisal Analysis Guidance (http://www.gavi.org/library/gavi-documents/guidelines-and-forms/joint-appraisal-analysis-guidance/).

3.1. Coverage and equity of immunisation

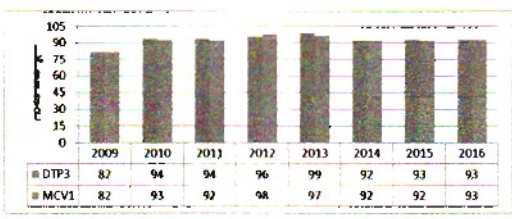
Please provide an analysis of the situation related to coverage and equity of immunisation in the country.

*Provide a summary of the difference in **coverage across various geographical areas, populations and communities** and the evolution over the past years. Relevant information includes: overview of districts/communities which have the lowest coverage rates and/ or the highest number of under-vaccinated children, number of vaccine preventable diseases (VPD) cases observed in various regions/ districts etc.*

Countries are strongly encouraged to include heat maps or similar to show immunisation coverage trends over time. Examples of such analysis are available in the Joint Appraisal Analysis Guidance (available via)

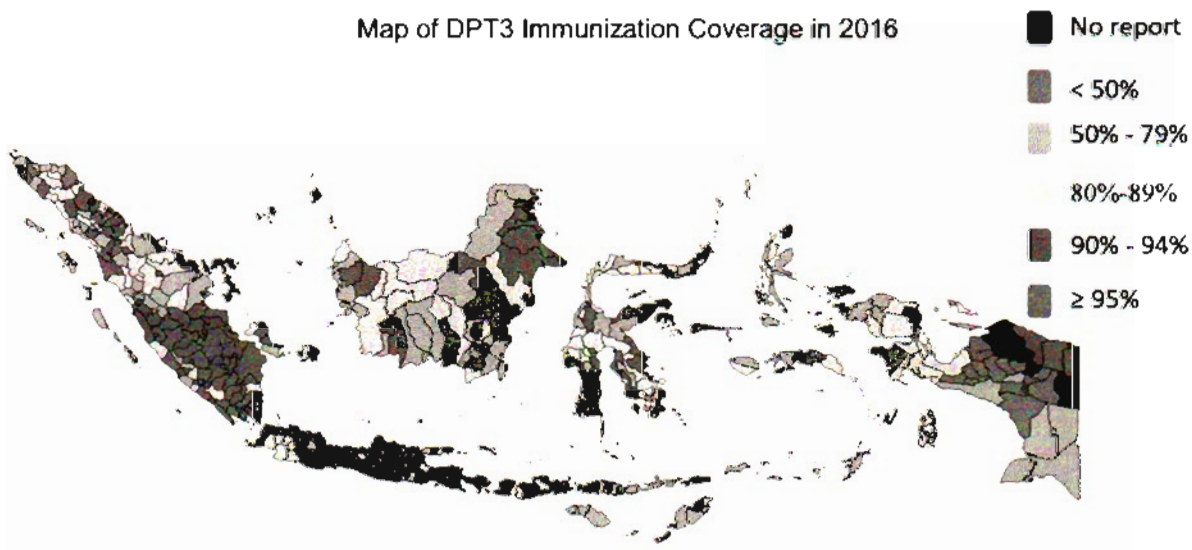
Coverage and Equity

Based on administrative data in JRF 2016, the trend of routine immunization coverage shows that the immunization program has reached a good performance (> 90%) in covering children as indicated in table below:



[5] For further information refer to http://www.gavi.org/about/governance/gavi-board/minutes/2016/7-dec/minutes/08a---fragile-settings,-emergencies-and-displaced-people/

The graphics also shows that immunization coverage in any antigen has been stagnant since 2014 – 2016. However, since last 5 years immunization coverage has been over 90%. Besides, reports of the progress of DPT-Hb-Hib3 in all districts throughout the country indicated there were 23 districts with coverage of below 50%, 107 districts with coverage of 50-79%, 107 districts with coverage of 80-89%, 74 districts with 90-94% and 199 districts with the coverage of more than 95%. There were 380 districts (73,9%) with the coverage of more than 80%, and there were 21 out of 34 provinces having coverage below of national level 91.4%. Those data indicated there have been disparities of immunization coverage among regions.



Immunization System

Service Delivery

Indonesia is the largest archipelago in the world with approximately of 17,500 islands with a population of more than 250 million. The target of infant in 2016 was 4.7 million. The country has 9,767 Health Centers (puskesmas) and 289,635 posyandu. The immunization schedule covers most of the recommended vaccines by the World Health Organization including rubella (2017). Majority of immunization services are provided monthly in Posyandu. However, in remote areas Indonesia implements sustainable outreach services (SOS) which is conducted 3 – 4 times a year in an integrated package. All vaccines in the national immunization schedule are provided free of charge in the government health facilities, however, private service providers may charge certain fees. Coverage data from private sector is still not reported uniformly.

Medical doctors, midwives and/or nurses can deliver immunization services. The availability and capacity of health workers are the main factors influencing the immunization coverage. In 2016, there were 16,527 medical doctors and 120.091 midwives working spread over 9,767 health centers. More trained health workers are needed to enhance the reach and coverage of immunization service specifically in peri-urban areas, hard to reach areas and for supervision.

Cold Chain Status

Cold Chain Equipment Inventories (CCEI) has covered all provinces in stepwise manner in 2014, 2016 and 2017 to contribute to effective vaccine management improvement plan.

In 2016, using country and Gavi fund, the MoH has procured 2,493 units of CCE resulting 79% of health centers using standard CCE. Meanwhile in 2017, using country fund MoH has procured 1,861 units of CCE resulting 92.2% of health centers. It is expected that the target of 100% will be achieved in 2018 by procuring 1,292 units of CCE using country and Gavi fund.

Unimmunized Children.

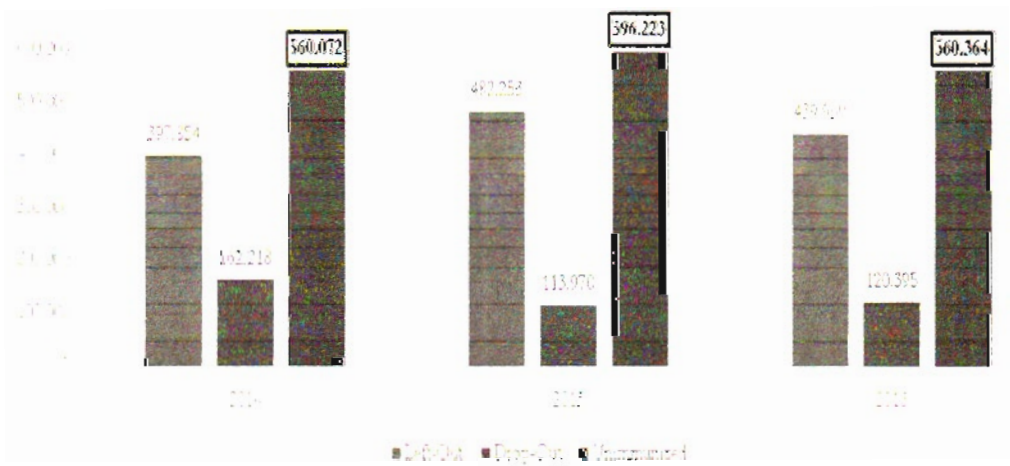
EPI administrative data from 2014-2016 reported 1,7 million children unimmunized in 514 districts in Indonesia. Surprisingly, in the 60 districts with highest number of unimmunized children, the number of unimmunized children in urban area (479,988 children) is five times higher than that of in rural area (101.508). Among other factors, it might be due the RR system that has not covered privates health providers and also caused by great number of refusal of the household for immunization.

The national target for the dropout rate was less than 5%. The drop out rate of DPT1-DPT3 in 2016 was 2% at national level which was much improved as compared to the condition in 2009 (7%). Similar with the drop out rate of DPT1-MCV in 2016 that was better than that of in 2009. Ministry of Health has identified 120 districts (urban and rural area) required acceleration in routine immunization program

Although immunization coverage has shown high levels of overall performance, some areas still have low coverage, oftenly in the inaccessible or remote locations. The problems typically caused by limited transport cost, challenging geographic area, or small and dispersed populations. As a result, service delivery is difficult and expensive to implement.

National EPI unit continued to implement Sustained Outreach Service (SOS) in selected areas of Indonesia. In addition, the problem suggested the importance of default tracking to assure all children at the community got vaccinated. Efforts to increase coverage vaccination need collaboration with community and stakeholders. Government need to continue to work with international partners such as UNICEF and WHO to strengthen routine immunization.

Graph. Number of Unimmunized/Partial Immunized Yr 2014 - 2016

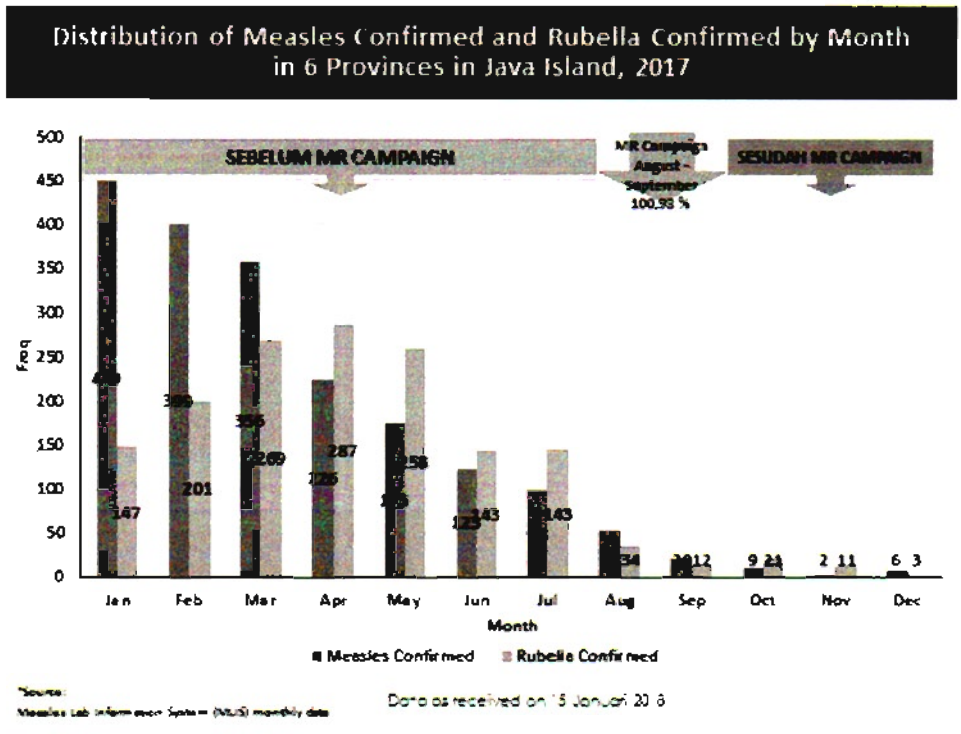


VPD Surveillance

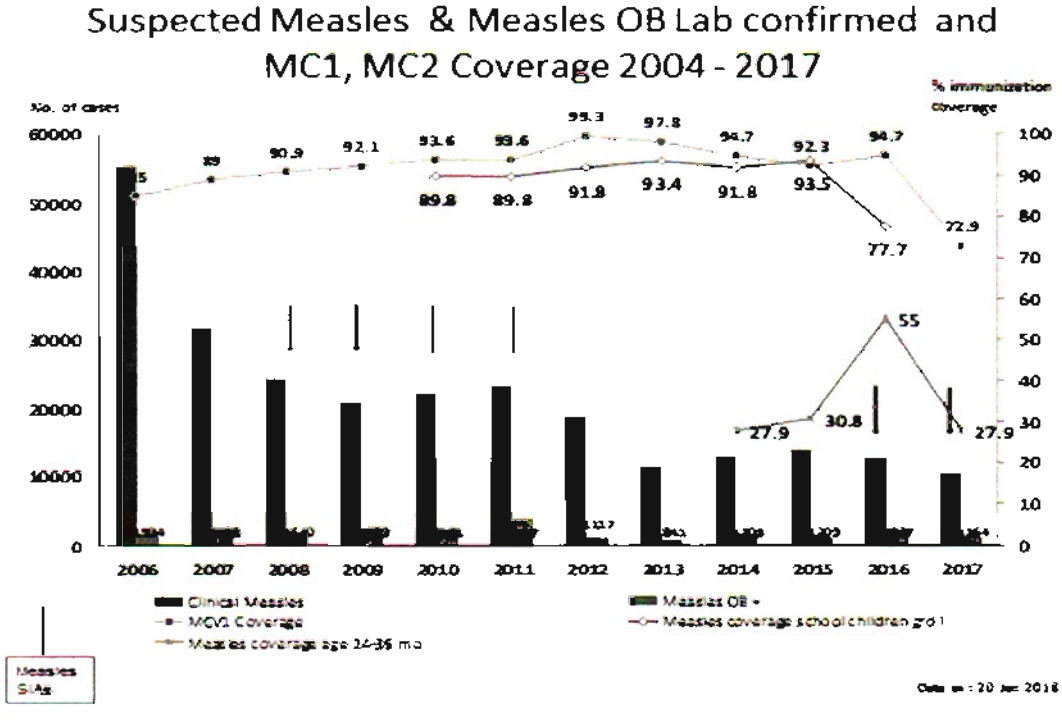
National non-polio AFP rate in 2016 was 1.98/100,000. It is below the target of 2.00/100,000 children aged less than 15 years. Meanwhile the adequate specimens reached was 83.5% which was higher than target of 80%. In 2017, the non polio AFP rate was 2,34/100.000 and AFP rate was 2.05/100.000, because 330 cases still pending classification.

Indonesia has implementing the Case Based Measles Surveillance (CBMS) by phase since 2007. Nationally 20 – 50% suspected cases have test their specimens, except in 6 provinces where the number of reported cases are low, the specimen tested for total suspected cases. In 2016, 67% of clinical measles cases have their specimen tested, 2949 (36,8%) of them were measles confirmed and 1341 (16,7%) were rubella confirmed . Meanwhile the total confirmed measles outbreak were 264 events with 2044 cases in 2016 and in 152 events with 1164 cases in 2017. The data 2016 and 2017 still not closed yet, because there are some cases still need provincial clarification.

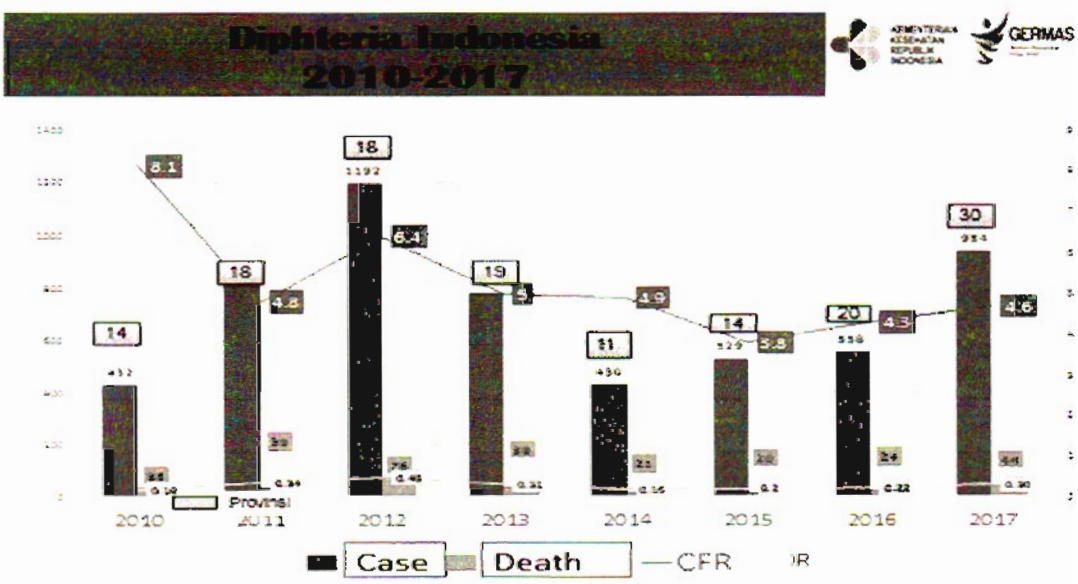
In August – Sept 2017, MR campaign was implemented in 6 provinces in Java Island, the coverage was 103 %. Following the campaign, number of rubella and measles cases dramatically declining as can be seen in the table below.



These number are still low and under reported, where the private clinic still not included in to the reporting system and >40% have discrepancies of the data between surveillance data and laboratory data.



In 2016, 558 suspected diphtheria cases were reported from 24 provinces and 24 death (CFR 4,3%) and 954 suspected cases in 2017 from 30 provinces with 44 death (CFR 4,6%). In 2016, final classification of 352 cases have their specimen tested, 3,7% of them were Lab positive (culture) and 76,9% of them were toxigenic. In 2017, 261 cases have their specimen tested, 8 % culture positive and 80,9% of them toxigenic. ORI have been conducted in some areas, the target were vary. Because the OB still on going, wider ORI in selected districts have been conducted to the children below 19 years old.



Various survey data shows that in Indonesia there is significant inequities in immunization coverages.RISKESDAS (Basic Health Survey -2013) shows that is wide variance of coverage among children . Eg child living in Jogjakarta has > 80% chance of getting fully vaccinated in comparison to a child living in Papua or Aceh . The below date from RISKESDAS reflects these

% Full Basic Immunization among Children 12 – 23 months by province in Indonesia
(Basic Health Research-NIHRD, 2013)

Province	Complete Vaccinated	Partial Vaccinated	No Vaccination
Urban Area			
Yogyakarta	83,1	15,7	1,1
Bali	80,8	18,0	1,2
Gorontalo	80,6	16,7	2,8
Jawa Timur	74,5	21,7	3,7
Rural Area			
Papua	29,2	34,3	36,6
Maluku	29,7	48,6	21,7
Aceh	38,3	41,9	19,8
Sumatera Utara	39,1	44,5	16,4

Apart from Geographical inequities Immunization program, there also social inequities which are reflected li the below analysis table. Except for gender, all other key factors such as parent's education, Rural / Urban and wealth (rick / poor) effect the vaccination status of a child.

This situation is very challenging as current vaccines in EPI program are not reaching all children in all areas and all sections of society. Introduction of new life saving vaccine or under used vaccine will not be

able to provide maximum impact as these vaccines are also unlikely to reach the poor, marginalized children. The results of SDKI 2017 similar with Basic Health Research 2013.

Inequities in Basic Immunization among Children 12 – 23 months
(Demographic Survey and Health – Indonesia – SDKI 2017)

No.	Characteristic	% Complete Basic Immunization
A	**Gender**	
	Male	65,0
	Female	65,5
B	**Area**	
	Urban	68,3
	Rural	62,3
C	**Education Background**	
	Mother no education	44,5
	Mother with high school education	70,5
D	**Wealth Quintile**	
	Lowest Wealth Quintile	54,1
	Highest Wealth Quintile	71,5

3.2. Key drivers of low coverage/ equity

Please highlight key drivers of the low levels of coverage and equity highlighted in the section above. For those districts/communities identified as lower performing, explain the ***key barriers*** *to improving coverage.*

- ***Health Work Force****: availability and distribution of health work force.*
- ***Supply chain****: key insights from latest EVMs and implementation of the EVM improvement plan.*
- ***Demand generation / demand for vaccination****: key insights related to demand for immunisation services, immunisation schedules, etc.*
- ***Gender-related barriers***[6]*: any specific issues related to access by women to the health system.*
- ***Leadership, management and coordination****: leveraging the outcomes of the Programme Capacity Assessment and/or other assessment, please describe the key bottlenecks associated with management of the immunisation programme; this includes the performance of the national/ regional EPI teams (e.g. challenges related to structure, staffing and capabilities), management and supervision of immunisation services, or broader sectoral governance issues.*
- ***Public financial management:*** *the extent to which funds requested are made available in a timely fashion at all levels, highlighting particular bottlenecks in the disbursement process.*
- ***Other critical aspects****: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports*[7]*.*

- Some areas still have low coverage, peri urban migrant population, population living in often in the inaccessible or remote locations. The problems typically caused by limited transport cost, challenging geographic area, or small and dispersed populations. As a result, service delivery is difficult and expensive to implement.
- Other challenges include social barriers such as poor, migrant, and mobile population.
- From the supply side, capacity of health workers, specifically IPC skills to explain the parents on the importance of all antigens, risk for non-vaccination is limited; these along with high turnover of human resources are considered serious challenges.
- Some enabling factors such as political commitment of high officials at national and sub national

[6] Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women tend to be the primary caretakers of children, but sometimes lack the decision-making power and resources to access or use available health services.
[7] If applicable, such as Full Country Evaluations (relevant for Bangladesh, Mozambique, Uganda and Zambia) and Technical Assistance evaluations (conducted for Gavi Partners' Engagement Framework tier 1 and tier 2 priority countries).

level toward the importance of immunization also were considered as the challenge toward immunization.

- In Indonesia's decentralized context, inter fiscal government transfer is significant and accounts for almost 6% of the GDP while the system of intergovernmental transfers is complex and fragmented, some earmarked for inputs; for the reminder, district governments have discretion over how budgets are allocated and how much would be spent on health, which leads to wide variations in local health spending. Indonesia does not have an explicit result-based orientation in its system of intergovernmental fiscal transfers.

Strategies:

a. Advocacy to gain political commitment from authorities to support immunization, i.e. develop regulation that immunization is mandatory.
b. Implement/create micro planning in districts and health center level, focus on defaulter tracking
c. Supply side:
   - High operational cost to remote area. To address this challenge, EPI unit has piloted a strategy called Sustained Outreach Service (SOS) in selected areas of Indonesia. Provisions of immunization and vitamin A supplementation are usually considered the minimum package for SOS.
   - To address the problem of unvaccinated children within high risk communities in urban slum areas, MoH also conducts a pilot project called Reaching Every Community (REC), located in DKI Jakarta province. Providers and public health systems use evidence-based strategies in maintaining overall immunization coverage and addressing disparities to improve coverage in vulnerable subpopulations.
   - It has been difficult to address the issues of high turnover human resources. It is much related to the policy of decentralization.

d. Improve demand creation:
   - Disseminate immunization communication strategy among health care workers, IEC play a very critical role in bringing in awareness on the benefits of immunization. It requires well trained health personnel in personal communication, and efforts empower the community in immunization activities
   - Continue raising awareness among caregivers on the benefit of immunization.
   - Individuals, families, and communities must understand the benefits and risks of immunization. Some reasons for hesitancy, the growing anti-vaccination groups and negative campaign on immunization undoubtedly amenable to improved communications and advocacy initiatives designed to counteract and to increase understanding of the value of immunization

3.3. Data

*Provide a succinct review of key challenges related to the availability, quality and use **of immunisation data**. This section should at least cover insights on coverage data (target populations, number of children vaccinated) and could also cover topics such as vaccine supply chain data, VPD surveillance data, AEFI data.*

Please take the following aspects into account:

- ***Compliance** with Gavi's data quality and survey requirements (the requirements are detailed in the general application guidelines available on www.gavi.org/support/process/apply/). If you are not compliant, explain why.*
- *Highlight key **challenges** pertaining to data availability, quality and use, referring to results from most recent annual desk review, any recent assessments and implementation of immunisation data quality improvement plan. For example, are you aware of key limitations / weaknesses related to the quality of the data and data analyses you have used to inform this Joint Appraisal.*

- *Main **efforts / innovations / good practices** focused on improving data system strengthening and addressing key issues.*

Key Challenges

- Immunization coverage discrepancies in pockets within provinces and districts, and risk for vaccine preventable diseases (VPD) outbreak. Declining AFP Surveillance performance is posing risk to Polio free status, (measles and VPD outbreaks still occur suggesting population immunity gaps despite high reported administrative coverage);
- Discrepancies between administrative data and coverage survey

Efforts to improving data system strengthening and addressing key issues

The improvement of data management will be continued. Data recording and reporting system will be continuously reviewed and improved in order to reduce the discrepancies between administrative data and survey data on immunization coverage. Besides, the use of robust data management is required to increased data reliability to support the program management. The implementation of existing RR - so called *Sistem Informasi Puskesmas* (Health Center Information System) or *Sikda Generik* with the support from Gavi in 1.241 Puskesmas - will be monitored and evaluated. The development of Immunization RR as part of the existing system will be conducted in selected provinces to ensure all required data are collected and reported accordingly.

In addition, the implementation of surveillance is going to be included in the transition plan to ensure integration on the strategies and activities of EPI and VPD surveillance for the prevention and control of VPDs and periodic assessment / evaluation impact of immunization program related with VPD surveillance and also conduct analysis immunization financing if there are outbreak VPD due to low herd immunity in population

3.4. Role and engagement of different stakeholders in the immunisation system

Please provide relevant information on the role and engagement of the various stakeholders:

- ***National Coordination Forum** (ICC, HSCC or equivalent): the extent the forum meets the Gavi requirements (please refer to http://www.gavi.org/support/coordination/ for the requirements).*
- ***Civil society**: the role and engagement of civil society in the immunisation system in the past year (service delivery, demand generation etc.).*
- ***Other donors**: the role and investments of other bilateral and multilateral donor in the immunisation system. Please include information on possible reductions in non-Gavi donor support that influence the overall system capacity (e.g. reductions in Global Polio Eradication Initiative funding).*
- ***Private sector**: public-private sector collaboration, indicating possible vaccine supply between Government and private sector and the percentage of children receiving immunisation through the private sector.*
- ***Cross-sectoral collaboration**: e.g. collaboration between health and education programmes.*

❖ **The National Immunization Technical Advisory Group (NITAG)**

a. Conducts comprehensive policy analysis and determines the most optimal national immunization policy
b. Recommendation for new vaccine introduction
c. Provides advise to the national government on the strategy formulation for the VPDs control
d. Assists the national authorities in the monitoring and review of national immunization program performance and provides advise on how to strengthen

❖ **The National Committee for AEFI**

Conducts audit and causality assessment on the reports of Adverse Effect Following

Immunization and trains to build national capacity to strengthen AEFI surveillance

- **The Pharmaceutical Unit - MoH**
  Procures/ conducts procurement of vaccines and logistics through e purchasing mechanism and SAS
- **Province, District and Health Center**
  Implements activities to maintain and improve immunization coverage within their areas
- **Ministry of Finance**
  Coordination for allocation of annual and long term budget
- **Ministry of National Development Planning (Bappenas)**
  a. Formulating national planning and budgeting (annual, five years and long term
  b. Coordinate international development cooperation
- **The National Regulation Authority (NADFC)**
  a. Assess and evaluates all vaccines to be safe, efficacious and qualified prior to marketing authorization.
  b. Conducts pre and post-market control on vaccines safety comprehensively in collaboration with the National Committee of AEFI
  c. Develops and implements pharmacovigilance both for vaccine used in public and private services.
  d. Involves in the preventive occurrence of counterfeit vaccine.
- **Health Promotion Unit - MoH**
  a. Develops appropriate communication strategy to enhance demand promotion
  b Develops proper Information Education Communication (IEC) materials
  c. Conducts promotion, advocacy and sensitization on the importance of immunization
- **Partners and Donors (WHO, UNICEF, World Bank, GAVI, CHAI, etc)**
  to provide financial and technical assistance
- **CSO, religious and community leaders, cadres, etc**
  a. Implements activities to promote the importance of immunization program at grass root level
  b. Raising community empowerment to support immunization program
- **Ministry of Education, Ministry of Religious Affair**
  Coordinating immunization services at public schools and religious schools
- **Ministry of Home Affairs**
  a. Coordination development planning for local budget (APBD)
  b. Coordination immunization service at public school
- **Private sector**
  Private sector reporting is still not synchronized in National EPI coverages, as many private hospital and doctors Bidans / do not use vaccines which are given by Public sector, they use their single dose presentation of vaccines like monovalent HB, IPV, and Hexa valent vaccines, plus other antigens which are not part of national EPI program like Rota, PCV and Dengue. In 2017 efforts are being made to collect private sector vaccine coverages data and integrate this information in National coverages

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

*Provide a succinct analysis of the performance of Gavi grants for the reporting period. Describe **how Gavi support is contributing to advancing the performance of the overall immunisation programme** and health sector strategies (with a particular focus on those districts/communities with lower coverage), and how the barriers identified in section 3 above are being addressed, stating -as relevant- **good practices and innovations.***

This analysis should cover all Gavi support received, including NVS, HSS and CCEOP. This section must address the following:

- ***Achievements against agreed targets**, as specified in the grant performance framework (GPF), and other grant-related activity plans. If applicable, reasons why targets as specified in the GPF have not been achieved, identifying areas of underperformance, bottlenecks and risks.*
- ***Overall Implementation progress** of Gavi grants including **NVS**, **HSS** (incl. performance based funding **PBF**) and **CCEOP**.*
- *Past performance for measles and rubella (immunisation coverage analysis and rubella surveillance, performance[8]) and progress against the country's **measles-rubella 5 year plan**.*

*Please mention any other **relevant initiative not supported by Gavi** that addresses the key drivers of low coverage (described in section 3).*

Pentavalent (DPT-HB-Hib)

Indonesia introduced Pentavalent vaccine in July/August 2013 started in 4 selected high-functioning provinces with financial support from GAVI. The remaining 30 provinces introduce pentavalent vaccine in June 2014.
All provinces conducted sensitization workshops for their district and puskesmas staff prior to the pentavalent introduction/immunization schedule change using GAVI vaccine introduction funds. After all the provinces had implemented the introduction of the pentavalent vaccine, the evaluations of the activities were required. Post Vaccine Introduction Evaluation (PIE) conducted in 4 selected provinces (DKI Jakarta, South Sulawesi, North Sumatera and West Kalimantan) by Department of epidemiology, Public Health faculty, University of Indonesia and MoH RI and assisted by WHO.
The PIE result found out that there was inadequate socialization in implementation of new vaccines and new schedules. Socialization to cadres and communities (mothers or parents) should be delivered before the immunization given; mothers did not know DPT booster and second dose of measles.

Performance : The target number of infants in 2015 is 4,784,333 infants (based on surviving infants – Pusdatin). The coverage of DPT-Hb-Hib3 is 93% (4.455.314 infants). The drop out of DPT1 - DPT3 in 2016 was 2.0% and the drop out of DPT1- MCV1 was 2.9% . The target was less than 5%. A low drop-out figures reflecting either quality of immunization services was good or mothers had good access to immunization services. Indonesia use DPT-HB-Hib of 5 doses presentation with estimated wastage rate is 1.25%.
Indonesia self-procures Pentavalent from the national manufacturer Bio Farma. Indonesia has purchased 22 083 000 doses (by country funds) and 32 546 435 doses (by Gavi funds) and fully self-financing pentavalent vaccine since 2017.
The co financing of NVS Pentavalent as described in table below

Table : Co financing Pentavalent Vaccine 2013 – 2016

Year	Required by DL in doses		Actual by Contract in doses	
	GAVI	Country	GAVI	Country
2013	3.688.100	917.100	7.081.205	1.963.045
2014	13.415.500	6.607.700	10.002.395	11.402.120
2015	7.770.200	11.655.300	7.700.200	9.764.170
2016	3.848.600	15.394.200	3.938.600	9.417.100
2017	0	19.529.400		22.083.000
Total	28.722.400	54.103.700	28.722.400	54.629.435

[8] Please include analysis of MCV1 and MCV2 routine immunisation and MCV campaign coverage at national and sub-national levels (admin and survey data), information on case distribution by age, geography, vaccination history, etc. for measles and rubella (including CRS), including outbreaks, at national and sub-national level.

- IPV

The Government of Indonesia has identified a preference for using a Biofarma 5 dose vial stand-alone IPV currently , Biofarma is working with Sanofi Pasteur to enter into a partnership where Sanofi would supply Biofarma pre-formulated, inactivated IPV bulk that would be filled by Biofarma in a 5 doses presentation. The National Regulatory Authority (NRA) of Indonesia has been notified of the proposed Biofarma/Sanofi partnership approach and has given guidance on the regulatory requirements that would be entailed with this arrangement.

Considering of IPV readiness of IPV production by Biofarma, Indonesia use IPV 10 doses presentation at urban area and use 5 doses presentation at rural area.
Indonesia was conducted IPV introduction in June 2016 use IPV from Sanofi Pasteur. The Procurement of IPV was conducted in October 2016 supported by GoI and Gavi Fund. IPV was distributed in November 2016 to all provinces.

Year	Gavi Required by Decision Letter in dose	Actual Purchase by Contract in dose		Total (Doses)
		Gavi	Country	
2016	2.400.000	1.864.875	570.875	2.435.750
2017	3.400.000	3.129.430	1.533.570	4.663.000
Total	**6.700.000**	**4.994.305**	**2.124.445**	**7.118.750**

Performance : IPV coverage 2016 was 1.9%, due to the fact that vaccine delivery to health centres by the end of the year 2016 and IPV coverage 2017 was 45.4% (Dec 2017)

- Measles Rubella

Indonesia decided to introduce MR vaccine in 2 phases commencing from 2017 to 2018 in following manner.

a. Phase I – August 2017, 53 % of the population (West Java, Central Java, East Java, DKI Jakarta, Banten and Yogyakarta) – 6 provinces in Java Islands
b. Phase II– August 2018, reaching 47 % of population– 28 provinces in outer Java Islands

Indonesia has launched MR catch-up campaign at 1st August 2017 by President RI at Madrasah Tsanawiyah Negeri (Islamic Junior High School) 10 in Sleman, Yogyakarta. The target of MR catch-up campaign phase 1 is thirty-five million children in the Java Island (53% of total population) and implementation of this campaign conducted in two months (August to September 2017).
The target children of 9 months - < 15 year for MR catch up campaign phase 1 is 34,9 billion and the target of number of schools is 240.636 with 3,466 public health centres in 119 districts spread across six provinces. While the target of infant age 9 mos for MR introduction is 1,2 billion
MR vaccine is produced by SII and imported and distributed by Biofarma. MR vaccine procurement for MR campaign first 1 , as follows

Year	Gavi Required by Decision Letter in dose	Actual Purchase by Contract in dose		Total (doses)
		Gavi	Country	
2017	41,227,700	22,774,500	24,997,000	47,771,500

Performance : National MR catch up coverage 2017 is 100,9%, all provinces has reached MR coverage more than 95% while there are 7 of 119 districts cannot reach MR catch up campaign coverage 95%. Rapid Convenience Assessment (RCA) was conducted after MR catch up campaign at communities involving external monitor from other countries and international partners (WHO, Unicef)
An independent coverage survey to assess the Phase one is underway in six provinces and the report

will be available very soon.

Second phase of MR catch up campaign will be conducted in remaining 28 provinces where children 9 months to <15 years will be given one dose of MR vaccine, A total of 32 million children will be targeted in this second phase which will be in months of Aug and Sept 2018. This phase will have additional technical, logistical and access challenges, Also some of these areas have population which is hard to reach, living on remote islands and hard to reach areas. Many of these districts and provinces have limited technical and managerial planning capacities and additional assistance will be provided by MOH and partners to enhance their capacity and ensure better preparedness for the second phase.

- HPV

Governor Yogyakarta - Indonesia launched the HPV demonstration program at Kulonprogo districts on 9 October 2017 and was attended by key stakeholders.

The target of HPV demonstration program is the 5th grade primary school (girls aged 11 – 12 years old) in 2 districts in Kulon Progo and Gunung Kidul in Yogyakarta Province. The first dose was given in October 2017 and for the next will be given in August in each year soon after the commencement of the new school year, in order to complete the 2 doses within each academic year and align with existing school holidays and examination date. The strategy included at the national technical guideline of HPV demonstration program which is integrated with school base immunization month (Bulan Imunisasi Anak Sekolah - BIAS).

Training of trainers was organized by Yogyakarta Province and assisted by central level. The training involve provincial and district officer, health workers, teachers, education office, policy maker, community and religious leaders. The same training has been done at the district level involving 41 health centres with 125 health workers (medical doctor, midwife, and nurse) and 932 school leaders or teachers.
Implementation of HPV demonstration program was conducted in 370 schools at 21 health centers in Kulonprogo and in 562 schools at 30 health centers in Gunung Kidul.
Procurement of HPV vaccine and device supplies (ADS dan safety box) was conducted through UNICEF. The HPV Quadrivalent vaccine single dose and device supplies was received in first September 2017 at point of entry and directly deliver to vaccine storage at Yogyakarta Province with good condition.

Base on Gavi's Decision Letter dated August 2016, the number of HPV vaccines dose is 20.800 doses, ADS 21.900 pc and 250 pc safety box. According NADFC regulation that Vaccine lot release should be conducted as part of the regulation of vaccines and involves the independent assessment of each individual lot of a licensed vaccine before it is released onto the market or distribution to health facilities. NADFC was taken 20 doses as sample to process lot of release of HPV vaccine as requirement. The number of HPV vaccine received by Province Yogyakarta's storage is 20.780 vial. HPV vaccine and device supplies were distributed to district and Puskesmas (health center) by the end of September 2017.
Performance : The coverage for HPV Demonstration Program in Kulon Progo is 99.9% and Gunung Kidul is 99.7%. Immunization refusal rate in school children of Kulon Progo and Gunung Kidul are very low. The health centres and school officials' participation also strongly support the implementation of the immunization of HPV at school.
A post introduction evaluation (PIE) is being planned for this demo project in May –June 2018 and good practices and lesson learnt will be shared with other provinces/ districts where HPV is being planned for scale up.

- Japanese Encephalitis (JE)

JE vaccine introduction was expected to be conducted in 2017, but it was postponed to be 2018 due to the availability of the vaccine. Indonesia planning to conduct this campaign in March 2018 and introduce JE into routine immunization in May 2018.

JE campaign that will be given to target population aged 9 months to less than 15 years in all 9 districts of Bali Province, which will be followed by introduction of JE vaccine into routine program. Indonesia requests for JE vaccine in 5 -dose vial (SA-14-14-2) presentation. Estimated target population of 897,050 children. AES Surveillance is ongoing to monitor the disease and JE impact after vaccine introduction . A vaccine effectiveness study is being done in Bali province by Sanghla Hospital in collaboration of PHO Bali supported by IVI Seoul Korea..

JE /AES surveillance is also expanded to another 11 provinces which is like to generate further real time evidence of JE virus transmission and will be useful for review of JE epidemiology in Indonesia

- **HSS**

Indonesia had HSS grant which was active from 2008 to July 2017 supporting three major components : i) acceleration of improved DPT3 immunization coverage, ii) capacity development to improve data collection and reporting, and iii) improve competency of immunization staffs.

Result of the desk review on this grant indicated that DOFU and sweeping activities was able to reach the coverage of immunization in 26 of 31 target districts in 2016. Besides, the HSS grant supported the procurement of cold chain and implementation of activities related to the improvement of immunization quality such as: i) training of cold chain management for all 514 districts in the country, ii) training on Effective Vaccine Management in all 34 provinces; iii) Training on immunization management for 514 staffs from 305 government and private hospitals.

The HSS funds was also used for strengthening the demand promotion through: i) the establishment of communication forum in 3 provinced, and ii) the implementation of communication strategy in 373 Puskesmas in 31 districts in 10 priority provinces. The EPI needs to have strong coordination with other related units to ensure that these activities could be continued.

HSS grant has supported the development of teaching materials for 51 midwifery education institutions. The activity included the refinement of curriculum, printing the educational materials and training of lecturers. Based on the evaluation, The Ministry of Health has instructed to all government midwifery education institutions to use the material.

The Health Management Information System was one of the priority area of the HSS grant. The HSS effort was able to support the expansion of the new web based Recording and Reporting system. HSS grant supported the training on the RR system for 1,652 officers from 1,631 puskesmas in 12 provinces.

The EPI is currently developing the application of Web Immunization RR system tin order to align with the new Web HMIS of MoH. However, the existing decentralized system in the country would still be a challenge for the implementation of the RR system in the future

HSS Activities Supported by Gavi	Transition
DOFU and Sweeping immunization	The EPI plans to continue these activities and to ensure indicative funds for its implementation to be included in Health Operational Cost (BOK) at each primary health center (puskesmas) level with low coverage area
EVM Improvement Plan Activities	Currently there is funding allocated for these activities through the Block Grant especially for cold chain procurement, and central government for EVM implementation
Training on immunization management for private health providers in selected urban areas	The program plans to expand the training to 6 additional provinces especifically targeting urban hospitals through Gavi fund (CESAP budget) and its evaluation. This activities included in EPI routine activities using central budget
Demand Promotion Activities	EPI collaboration with Health Promotion unit MoH and other stakeholders to promote routine immunization program (develop of PSA, printing and distribution of IEC material. This

	activity covered by central budget.

- **Country plans for Rota and PCV**

The introduction of Rotavirus vaccine (RV3) will be introduction after get recommendation from ITAGI and availability of vaccine. Biofarma currently underwent the phase 2 of clinical trial and vaccine efficacy study in collaboration with Murdoch Children Hospital-Melbourne. The clinical trial is expected to be completed by the year 2020. There is an on going Rota Surveillance in place in 5 provinces which is managed by Uinversity of Gajah Mada , Jogjakarta.

Meanwhile, BioFarma has also implemented the phase 2 and 3 of pneumococcus (whole cell) trial study in collaboration with PATH, Boston University in 2016. It is expected to be completed by the end of 2025. Currently, PCV demonstration program is implemented in West Lombok and East Lombok and will be expanded to Bangka Islands in 2018.

- **Specific Country Experience in Addressing the low coverage**

MoH in partnership with WHO with support from CDC has rolled out a routine Immunization strengthening project (START) .

Strengthening Technical Assistance for Routine Immunization Training (START) project focuses on building the capacity of district-level EPI officers and health center EPI staff in both key technical and management competency areas. The project does this by using under-utilized learning methodologies, including mentoring/coaching, direct on-the-job training, and multiple follow-up visits. This design is intended to 1) help increase the trainees' knowledge and skills and 2) to help support the sustained application of these abilities compared with traditional training methods of workshops and rare follow-up/feedback. However, even when training is provided to immunization staff, too often it is conducted in an ad-hoc manner, many times through an ineffective cascade-style in crowded workshops that use one-way communication (e.g., lectures and information-giving) as the primary training method. In addition, seldom is there adequate follow-up from supervisors or managers to reinforce the application of knowledge and abilities covered in the training programs.

Phase One of the program has been implemented in 7 districts in Banten Province and 5 districts in North Sumatera Province from 31 August 2016-February 2017.

District and health facility EPI staff were mentored and trained at their work sites. Each of the selected low-performing facilities received an average of five visits from the consultant and district officer during the six-month intervention. Monitoring data demonstrated that improvements in planning, data analysis, defaulter tracking, and supervision occurred as a result of the intervention, and both district and facility EPI staff expressed appreciation for the support the project provided and the training approach used.

Ten selected technical person have been given Agreement Performance of Work (APW) contract, oriented, and deployed to support capacity-building of immunization program staff. During the final review meeting, positive finding has been identified i.e. micro plan developed in all DHO and Puskesmas (42% increased)

- EPI updated monitoring chart updated in monthly basis (33% increase in DHO and 54% at Puskesmas level)
- defaulter tracking systems developed (67% increase at DHO and 69% increased at Puskesmas)
- Vaccine stock management updated by end of project (8% increase at DHO and 44% at Puskesmas level)
- 83% increase of RED prioritization at district level

Encouraged by these results START activities have been scaled up in new areas and many local governments are also investing in immunization activities to improve capacity and coverages

In addition, in early 2015 UNICEF Indonesia, funded by UNICEF HQ, initiated a Reaching Every

Community (REC) strategy combining with the use of RapidPro, in collaboration with Jakarta PHO and EPI-MOH. The project was implemented in poor urban slum areas of Jakarta, considering low vaccination rate and frequency of VPD outbreaks occurring among children of migrant population and poor families. Many children living in this areas were not fully immunized timely and often drop out from the vaccination session due to many reasons. Of those, was the un-compliance of caregivers toward their children's vaccination schedule, thus RapidPro – an SMS based platform/application – was used to remind the caregivers on their children vaccination schedule by sending automated SMS reminder to the telephone numbers registered into the system.

After a year implementation of REC strategy with regular supportive supervision and the use of RapidPro, the project showed a promising 25 points increment of the FIC rate, from 46% to 71% among children of 12 – 23 month in late 2015. The project is now expanded to different areas with similar criteria in Jakarta as an evidence based study and later will be measured statistically.

4.2. Management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Provide a succinct review of the performance in terms of financial management of Gavi's cash grants. This should take the following aspects into account:

- *Financial **absorption** and utilisation rates*[9]*;*
- ***Compliance** with financial reporting and audit requirements;*
- *Major issues arising from cash programme **audits** or programme capacity assessments;*
- *Financial management **systems***[10].

Expenditure and Balances

The financial status of Gavi can be seen in the following table

Table. Gavi Grant Status as of February 2018

Grant	Period	Approval (USD)	Disbursement (USD)	Undisbursed (USD)	Balance in country		TBD (USD)	For reprogramming to CESAP (USD)	
					IDR *)	USD		Partners	EPI
ISS (INS, VIG & HepB	2002-2007	40,103,844	40,103,844		89,411,392	6,774	6,774	-	-
CSO (Type A & B)	2008-2015	4,000,500	4,000,500		-	-	-	-	-
HSS1	2008-2015	24,827,500	24,827,500	-	23,569,530,590	1,785,570	692,371	-	1,093,199
VIG Penta	2013-2016	3,791,000	3,791,000	-	14,566,961,992	1,103,558	-	-	1,103,558
NVS Penta	2013-2016	51,176,500	44,321,000	6,855,500	78,532,727,676	5,949,449	-	6,155,500	6,649,449
VIG IPV	2015-2018	3,688,500	3,688,500	-	25,025,299,972	1,895,856	1,895,856	-	-
NVS IPV	2016-2018	19,288,500	10,975,500	8,313,000	3,104,443,439	235,185	8,548,185	-	-
VIG MR	2017	3,915,000		3,915,000	-	-	3,915,000		-
NVS MR	2017	27,769,500	27,769,500	-	29,228,249,949	2,214,261	2,214,261	-	-
NVS JE	2017	343,500	343,500	-	4,625,160,175	343,500	343,500	-	-
VIG JE	2017	100,000	100,000	-	943,171,650	71,452	71,452	-	-
NVS HPV	2017-2018	180,500	98,075	82,425	-	-	82,425	-	-
CASH SUPPORT HPV	2017-2018	195,000	170,000	25,000	1,857,870,525	140,748	165,748	-	-
Interest					27,437,294,171	2,078,583	174,789	-	1,903,794
Other income					2,874,393,763	217,757	217,757	-	-
Total		179,379,844	160,188,919	19,190,925	211,854,515,293	16,042,694	18,328,119	6,155,500	10,750,000

[9] If in your country substantial amounts of Gavi funds are managed by partners (i.e. UNICEF and WHO), it is recommended to also review the fund utilisation by these agencies.

[10] In case any modifications have been made or are planned to the financial management arrangements please indicate them in this section.

The remaining grant in country as of 1 February was IDR 211,854,515,293 or equals to USD 16,042,694 using the currency rate of USD 1 = IDR 13.200. Meanwhile, the undisbursed grant is USD 19,190,925.
NVS and VIG grant for all new vaccine introduction (Penta, IPV, HPV, MR and JE) have been implemented according to the plan. However, the implementation of HSS grant has been relatively slow. The absorption rate has been relatively low resulting in significant grant balance carried over from year to year. After 9 years of implementation, a cash balance of IDR 23,569,530, 590 or USD 1,785,570 still remained.
Among other reasons, the low absorption of grant caused by the fact that Ministry of Health, Provincial Health Office and District Health Office have been required to meet the public expenditure targets. There was less focus on donor supported program, and the execution of certain activities, including those activities supported by Gavi, were a lesser priority. However, there was notable improvement in the budget execution rate of after the last reprogramming in 2015.
Based on the preliminary result of the Gavi Auditors, the financial management and expenditure control was rated as partially satisfactory. The Gavi Auditors has proposed several recommendation for the improvement of the financial management system and to avoid future underspending of Gavi's fund.
The recommendation on the financial management and expenditure control included various issues on the area of : i) budget management and control, ii) financial records and reporting, iii) Cash and bank management. The Ministry of Health has accepted recommendations and committed to follow up the recommendation in the future implementation of Gavi grant.

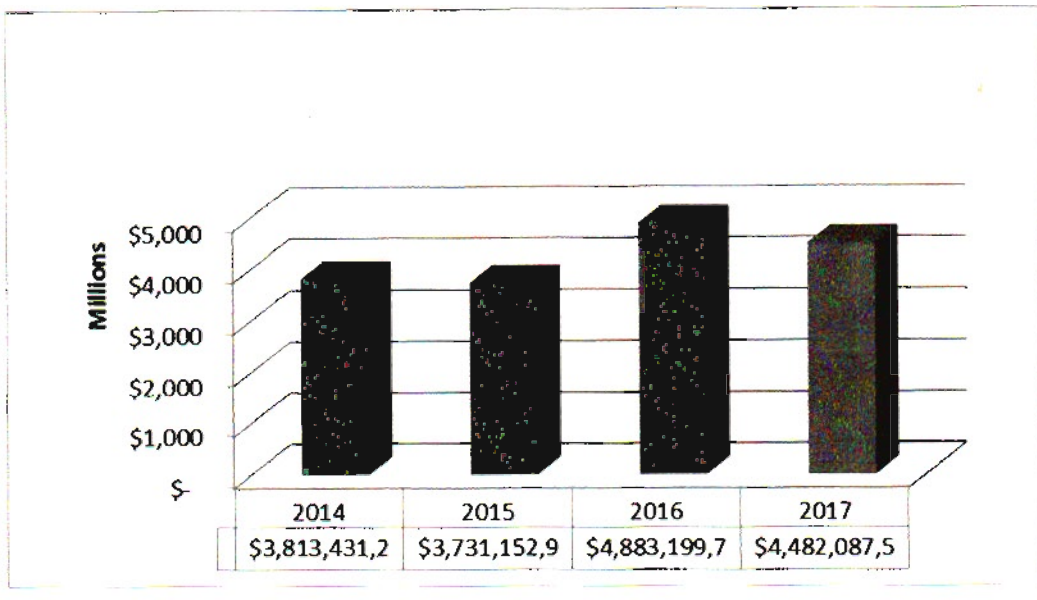
4.3. Sustainability and (if applicable) transition planning

Provide a brief overview of key aspects and actions concerning the sustainability of Gavi support to your country. Please specify the following:

- ***Financing of the immunisation programme**: key challenges related to the financing of the immunisation programme, including co-financing requirements.*
- ***Gavi transition planning**: if your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.*
- *If a transition plan is in place, please provide information on the following:*
  - *Implementation progress of planned activities;*
  - *Implementation bottlenecks and corrective actions;*
  - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
  - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
  - *Submit a consolidated revised version of the transition plan.*
- ***Polio transition planning**: If your country is transitioning out of immunisation programme support from other major sources, such as the Global Polio Eradication Initiative, specify whether the country has a transition plan in place. If such a transition plan exists, please briefly describe it. If no transition plan exists, please describe plans to develop one and other actions to prepare for polio transition.*

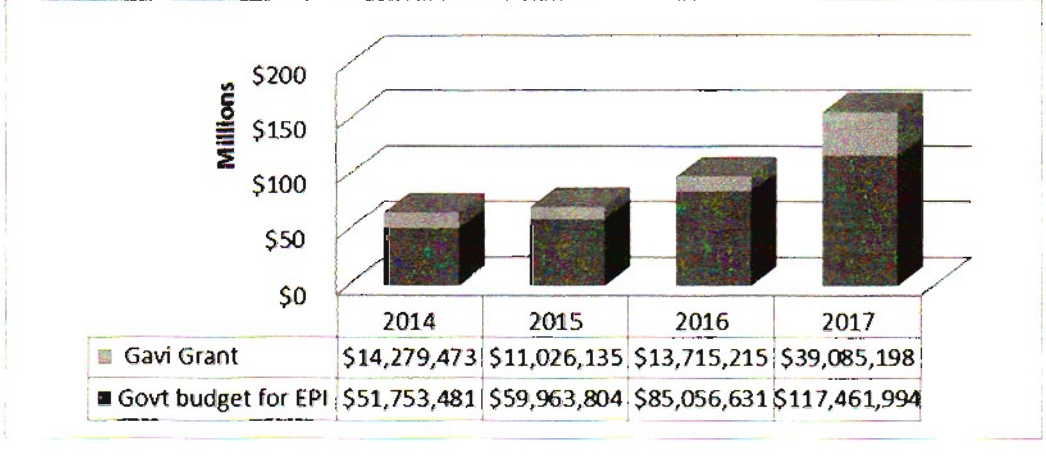
Along with the increased government expenditure for health budget in the period of 2014-2017, the country budget for immunization has been positive, even significant increased in 2016 and 2017.

Graph: National Budget for Health (APBN) 2014-2017



Similarly, the proportion of Gavi budget in financing the immunization program (operational and vaccines) has been steadily in the range of 14-25%.

Graph : Gavi Contribution for EPI



In 2016, Indonesia was in the last year of the accelerated transition phase. There is a need to develop a transition plan to ensure the smooth transition of the project. The transition plan with activities formulated in the document of CESAP is aimed to identify the potential bottlenecks for successful transitions and to support critical interventions to address the challenges of immunization program. Besides, this plan is also important to ensure full awareness of the government and all partners on the phase-out of Gavi support and implement the exit strategy for sustainability of the project. In addition, it has been redesigned to accommodate the recommendation of the Joint Appraisal mission.

The CESAP (Coverage, Equity, and Sustainability Action Program) activities will be funded using remaining gavi grant in the country. The grant is expected to be managed by EPI Unit MoH. Meanwhile, the undisbursed grant will be managed by partners (WHO and UNICEF).

The highest proportion in Gavi grant component is vaccine which is about 78% of the total grant 2013-2016. Therefore, the primary challenge for the sustainability of the Gavi grant in Indonesia is ensuring the sustained availability of new vaccines supported by Gavi such as Pentavalent, IPV, Measles & Rubella, JE and HPV

- **Transition/self-financing of Penta at the end of 2016**

Indonesia self-procures Pentavalent from the national manufacturer Bio Farma. Indonesia has purchased 28,722,400 doses (by Gavi funds) and has purchased 32,546,435 doses (by Country funds) and fully self-financing pentavalent vaccine since 2017.

- **Self-financing arrangement for procurement of Gavi-supported vaccines**

Indonesia self procures of traditional vaccine including new vaccine through the National Manufacture Biofarma. The Central government is responsible for procuring vaccines and other immunization logistics. National policy for vaccine and other logistics procurement is in place through one gate policy under the Pharmaceutical unit through e-catalogue mechanism.

- **Progress on polio transition planning**

Polio transition plan has been developed and already in 2017 the DGDC has undertaken several activities to that support sustainability planning, including:

- Holding a National Joint Review Committee Meeting for polio eradication, measles elimination and rubella/CRS control. Following review of the status of these programs, relevant expert committees made recommendations regarding program improvement
- Convening a Polio Eradication Sustainability Workshop with representatives from provincial health offices, government directorates and external partners. Breakout groups developed a series of recommendations related to improving immunization, surveillance and laboratory performance, and increasing the engagement of external partners and government directorates beyond the DSHQ to support polio eradication.
- Working with Gavi and other external partners (WHO, UNICEF, World Bank) to implement a set of activities, several of which indirectly support polio eradication, using reprogrammed funds
- Opening discussions with Port Health regarding instituting polio immunization requirements for departing and arriving travellers, similar to requirements put in place by Saudi Arabia and India, to protect Indonesia from WPV importations.
- Engaging this external consultant team to support the MOH in developing a sustainability plan.

The leadership shown by the DSHQ in assessing and addressing issues in polio eradication program activities currently underway, as well as the willingness to expand the portfolio of initiatives (e.g., vaccinating international travellers) bodes well for Indonesia's ability to maintain its polio-free status.

- **Updates on JKN**.

Under JKN (National Health Insurance) benefit package currently routine immunizations for children under five and tetanus immunization for pregnant women at primary health facilities are covered. In 2018, World Bank will conduct study on the analytical and advocacy work on better coordination between immunization and JKN.

In addition, in the frame of identifying the exit strategy for the Government of Indonesia is currently explore the possibility of utilizing the privilege of being the Gavi graduated country to purchase the new vaccine through UNICEF Supply Division. The Unicef vaccine has been proved to be much cheaper than the market price. Discussion on this matter has been intensive involving various stakeholders. The main

4.4. Technical Assistance (TA)

Briefly summarise key insights generated during the appraisal of Gavi supported Targeted Country Assistance (TCA) activities and milestones.[11] *Specify whether amendments to the currently planned and ongoing Technical Assistance activities and milestones are envisaged (short term). If changes are envisaged please provide a justification.*

Note: New Technical Assistance requirements for the next calendar year should be indicated in section 6 rather than this section.

- **WHO PEF-TCA**

TA from partners has been helpful in a number of critical areas both at national and subnational levels.specfically in planning and preparedness of new vaccines introductions. MR campaign and roll of of HPV, JE vaccination.
As Indonesia is also graduating from Polio GPEI grants, TA from WHO has also been helpful to sustain the AFP surveillance and advocacy for sustaining Polio free status in Indonesia

WHO assisted to develop Guidelines on reducing drop outs and field tested. Specifically defaulter tracking mechanism.
Enhancing knowledge and capacity of sub national and district level EPI managers (New MLM training module rolled out). All 34 provinces EPI staff trained on new MLM module Robust real time web based data collection and analysis medium term support to strengthen the VPD surveillance including laboratory diagnosis at national and sub-national level for measles, rubella, CRS, JE.

- **UNICEF PEF-TCA**

UNICEF provided full support on 2017 MR SIA targeting 35 million children aged 9 mo - <15 year in 6 provinces in Java, prioritizing on communication, socio mobilization and advocacy.
Communication strategies for MR campaign were developed, specifying on different target groups, which included development of advocacy kits, PSAs/TV spots short films/videos, key messages for SMS blast, art/graphic designs with key messages for dissemination in UNICEF/MOH/WHO and other partners' communication channels (Facebook, Instagram, Twitter, WhatsApp, U-report, Info Bidan, etc.).
In collaboration with EPI MoH, supported advocacy meetings with Min of Education, Min of Religious Affair, and Indonesia Child Protection Committees. Media advocacy were conducted through UNICEF's partner – Jawa Pos – in East and Central Java, to gain high officials commitment in supporting the campaign as well as enhancing public awareness, which was expanded to Banten, DKI Jakarta, and West Java provinces in last September and early October. UNICEF also supported the media briefing and media workshops, prepared and shared the risk communication strategy with the government.
Participated in the pre SIA assessment visits through deployment of UNICEF field officers and consultants in selected high risk districts in 5 provinces in Java to assess the province and districts readiness for the MR campaign. A real time monitoring and daily feedback mechanisms for the coverage were supported through the use of Rapid Pro.

The development of training package and modules on EVM was continued in 2017. Supply Chain training curriculum was established, modules were available in English and Indonesian language, and the training was conducted in early November 2017, participated by key national EPI, Surveillance and Pharmacy's staff. The Cold Chain Equipment inventory (CCEI) dashboard was established with a remote update feature that can be initiated as necessary. The dashboard will be updated as necessary, to capture a temperature monitoring data from Central Java, East Java and Jakarta Provinces. It will also linked to vaccine stock monitoring data, to be piloted in 2 provinces

[11] A summary of Technical Assistance approved under Gavi's Partner Engagement Framework (PEF) for the year under review and reporting status can be accessed via the PEF portal by registered users, or by contacting the Gavi Secretariat.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal[12] and any additional significant IRC or HLRP recommendations (if applicable).

Prioritised actions from 2015 Joint Appraisal	Current status
1. Conduct drop-out follow up (DOFU) and sweeping in 31 districts with low coverage/large number of unimmunized children based on baseline profile (after coverage surveys in each district)	21 districts (2015) 26 districts (2016) 29 districts (2017)
2. Reach the un-immunized children living in hard to reach areas using Sustainable Outreach Services (SOS) strategy	SOS immunization activities conducted in 46 districts in 1,310 villages 40 of 46 districts have DPT3 immunization coverage more than 80%.
3. Communication forum established for demand generation in partnership with LGAs, NGOs and others	Communication forum for immunization was established in West Java, South Sulawesi and West Sumatera. The communication forum consists of religious and community leaders, CSOs, experts and media (journalists) to increase demand for immunization, socialization of immunization program in West Java, South Sulawesi and West Sumatera utilising various platforms including social media platforms (Whats App groups, Instagram) and a website. The different forums are updated regularly to provide information to the community.
4. Recruitment of monitors (temporary contracts) to conduct intensive monitoring, technical assistance and follow up actions based on the results of the coverage survey at 31 districts	Cancelled
5. Cold-chain improvement (EVM assessment, inventory of cold chain and procurement of cold chain equipment)	**EVM Assesment** 85% (29 of 34 PHOs) that have sufficient stocks of any antigen during resupply period according to national EVM standards (can provide at least minimum stocks of vaccine during resupply) **Inventory Cold Chain** Data collection of the CCEI was completed in 34 provinces between 2014 – 2017 **Cold Chain Procurement** 92% PHOs in the country have standard CCE that are functional (2017)
Prioritised actions from 2016 Joint Appraisal	**Current status**
1. Strengthening national capacity to formulate evidence-based policies for introduction of new and underutilized vaccines	MoH, in collaboration with ITAGI will conduct a study on CEA of PCV and JE.
2. Strengthening data collection and analysis	In 2017, develop of EPI RR website and will continue to link the EPI RR website with Health Information Management System (HIMS) MoH

[12] Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

3. Strengthening Cold Chain Management including private sector	Will be implemented in 2019 including EVM Assessment in the private sector due to MR campaign phase 2 (outside java islands – 28 provinces)
4. Advocacy to decision maker and parliament related immunisation budget allocation including improving technical skill	Advocacy was conducted in 3 regional and attended by all Head of PHO and DHO and will be continued with monitoring and evaluation in selected districts
5. Strengthen Polio and measles Surveillance to monitor the disease trends and impact of vaccination programme	Mid Term review with Surveillance Officer , refreshing training in 8 provinces and distribution of IEC material of AFP to health workers
6. In view of number of new vaccine introductions and large scale SIAs to be implemented in 2017 there needs to be continued TA to the MoH	Yes, we need TA from partners to continue of new vaccine introduction implementation
Additional significant IRC / HLRP recommendations	**Current status**
1. Conduct a thorough review of the HSS performance so far as part of the preparation for the JA	Desk Review for HSS has been conducted in early 2018.

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being priorities in the new action plan (section 6 below).

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

*Briefly outline the **key activities to be implemented next year** with Gavi grant support.*

*In the context of these planned activities and based on the analysis provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support**, indicating timelines and Technical Assistance needs.*

Please indicate if any modifications to Gavi support are being requested, such as:

- *Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;*
- *Plans to change any vaccine presentation or type;*
- *Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.*

Note: When specifying Technical Assistance needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning, which will be informed by the needs indicated here.

Key finding 1	MR Campaign • Acknowledge the reported high coverage achieved during Phase 1 (>95% in all six provinces and 112 of 119 districts. • Acknowledge the critical success factors of phase 1: a. entire government systems were effectively mobilised from the office of the President, to national ministries of Education, Religious Affairs, Home Affairs; to provincial and district governments; b. active engagement of communities; and c. real-time monitoring of progress to the district level. • Acknowledge the technical support provided through WHO, UNICEF, CDC and broader partners. • Recognise the significant challenges posed by Phase 2: 28 provinces and 396 districts; diverse populations, varying levels of demand and diverse sources of vaccine hesitancy; varying district capacity; 77 very high risk districts and 104 high risk.' • Good management of AEFI cases
Agreed country actions	• Apply the lessons learned from Phase 1 in preparing for Phase 2, noting the importance of earlier preparation. • Endorsement the proposed technical and financial support that has been identified by WHO, UNICEF, and CDC. • Continue high quality preparation including the use of the SIA readiness assessment, local level monitoring and microplanning at the district level. • To sustain the gain from the campaign, ensure efforts to increase the coverage of MCV1 and MCV2. • Note the importance of a more comprehensive approach in demand generation. • Strengthen AEFI in remaining 28 provinces
Associated timeline	• Phase 2 preparations commencing in February for campaign over August-September. Post campaign coverage survey in November-December.
Technical assistance needs	• Extensive technical support needs have been identified through WHO, UNICEF and CDC. These are recommended for funding through PEF TCA in 2018, and through the re-programming of the undisbursed VIG MR to partners., WHO will hire and deploy mix of both national and international consultants in highest risk areas from 6 months • Technical support has been clearly identified in the PEF TCA 2018 submission. Such as need for marker pens, advocacy meetings to be organised with Professional organizations, IDI, IBI etc • TA and support from WHO to Strengthen, train National and Sub national AEFI committees to prepare for MR SIA phase -2. Monitoring of adverse events following immunization (AEFI) is an essential strategy for ensuring the safety of vaccines. and successful implementation of (ph-2 MR SIA) •

Key finding 2	Routine Immunization • Note with concern the current diphtheria outbreak with 46 districts in 26 provinces reporting cases in 2018. • Note that Indonesia still ranks amongst the top 10 countries with the highest number of un/under-immunized children for DPT3. • High drop outs and missed children tracking is weak • Note that the diphtheria outbreak and recent measles outbreaks in Papua point to continued challenges with coverage and gaps in the routine immunisation programme in parts of Indonesia. The outbreak further points to weaknesses in VPD surveillance/ • Acknowledge the need for increased sub-national engagement on routine immunisation and surveillance and recognise the opportunity provided by the MR campaign to strengthen RI sub-nationally. Needs high level advocacy inter sectoral • Non-use of open vial policy
Agreed country actions	• To continue to strengthen routine immunisation especially at sub-national levels, using the momentum from diphtheria outbreak and drawing upon the identification of very high and high risk districts through the MR campaign. Steps include: • Advocacy to provinces during the national meeting in 2018 , Minister of Health to highlight EPI as a priority in National Health meeting o Validating coverage data o Analysing data better to identify unvaccinated pockets and follow up action o Identifying the gaps in reaching these pockets, o Institute the practice of immunisation record checking at school entry o Improved service delivery at subnational level, including full funding for the operating costs. o Addressing demand side issues, notably sources of vaccine hesitancy, including concerns that vaccines are haram. A more comprehensive approach in demand generation o Continued strengthening of the cold chain o Continued and thorough outbreak investigation and response. o Continued monitoring and time addressing of AEFI issues • Recognise the need to focus on microplanning as well as local area monitoring to reach unvaccinated. • Use the MR campaign and other upcoming campaigns to strengthen the RI. Development of new cMPY for EPI-Surveillance program for 2020-2024 to be in line with RPJM • Study to llok into fesibility of MDOVP • Implement/ socialize the newly developed defaulter tracking guidelines
Associated timeline	• 2018/2019 making use of unspent Gavi grant funds and savings
Technical assistance needs	• A focus on subnational technical supports as identified in the revised Coverage Equity and Sustainability action plan. • WHO to deploy sub national TA in province s/ districts with large no of un vaccinated children to help accelerate coverage ,reduce drop outs. • WHO to provide TA for new cMPY drafting • Study on use of MDOPV • Strengthen defaulter tracking guidelines / tool

Key finding 3	Routine data, VPD surveillance, and public health laboratories • Note the need to strengthen the network of public health laboratories and improve VPD surveillance. • Acknowledge the need to improve outbreak detection and response, and the steps towards a comprehensive approach: o having trained staff at local level o the importance of data quality. o using available data for action. o Capacity building towards evidence-based decision making process. • Acknowledge the introduction of a web-based routine reporting system while recognising the need for a more strategic vision and plan going forward. Note the continued work on the SIKDA Generik (HMIS) and efforts towards greater data integration across the Ministry. • Encourage greater coordination with Riskesdas team in obtaining more accurate data and review of available data to inform official coverage estimates. •
Agreed country actions	• Provide a proposal on the use of unspent HSS grant funding to support the strengthening of the public health laboratories. The proposal should be time-bound (2018/2019), with costed activities and clearly aligned with existing WHO and CDC technical support. • To work towards a comprehensive system for VPD surveillance, addressing: o Immunization data quality and management o Surveillance and laboratory data validation o Integrating data o Data analysis, data sharing and utilisation of data for action o Reducing segmentation, finding a seamless way for EPI to understand what's happening. o MR surveillance to be enhance specifically in Jawa island post MR SIA to monitor impact of SIA o 13 sentinel sites CRS surveillance is strengthened to monitor, presence or absence of endemic rubella virus transmission in the presence of a well performing surveillance system o
Associated timeline	• 2018/2019 with funding support from reprogrammed Gavi HSS and CESAP.
Technical assistance needs	• Support to strengthening public health laboratories planned using reprogrammed HSS. Surveillance activities through revised CESAP. • TA from WHO at sub national level to enhance VPD surveillance • TA from WHO for Strengthening lab capacity, • TA for WHO for PHEOC capacity building, enhance skills in data analysis, mapping etc.
Key finding 4	Engagement with private sector – providers, health facilities, schools • Note the growth in the private health sector and acknowledge the challenges posed for immunisation service delivery through private sector providers. o Poor cold chain, use of non WHO pre-qualified equipment, poor vaccine management, lack of routine data reporting, trained vaccinators, IEC. • To improve quality of programs and address challenges within private providers.
Agreed country actions	• Need for greater engagement with private sector providers and health facilities. Regulatory framework to ensure private immunization service providers comply with MoH guidelines. • Advocacy with private sector for coordination

Associated timeline	2018/2019 with funding support from reprogrammed Gavi HSS and CESAP
Technical assistance needs	WHO TA for coordination with professional organixation. Coordination meetings at sub national evel with Processional organization
Key finding 5	New vaccine introductions: • Note the progress on new vaccine introductions in Indonesia: o IPV introduced in 2016 o HPV vaccine demonstration program in DKI Jakarta in 2016; two districts in DI Yogyakarta in 2017. o PCV demonstration program in East Lombok and West Lombok in 2017. o MR Vaccine was introduced in 6 provinces in Java in 2017 and the remaining 28 provinces in 2018. o Japanese encephalitis (JE) vaccine to be introduced in selected area: all districts in the province of Bali by 2018 o Rotavirus – clinical trials. • Note that vaccine costs and procurement, and domestic production capacity through BioFarma are important considerations for MoH in scheduling new vaccines for introduction. • Note that Gavi transition status precludes Indonesia from receiving new vaccine support. • Note the Gavi price commitments from manufacturers for transitioned countries and the opportunity for Indonesia to procure certain vaccines (e.g PCV, Rotavirus vaccine and HPV vaccine) through UNICEF Supply Division. Acknowledge the regulatory and public procurement challenges to this.
Agreed country actions	• Develop, with the support of partners a New Vaccine Strategy, expanding upon the plans outlined in the cMYP - a clear roadmap for planned introductions with costed scenarios for introductions in the short, medium or longer term. • With the support of partners use the NVI Strategy and costed scenarios to inform other government agencies on the financial implications of the new vaccine introductions. • Ensure that new vaccines can be evaluated and become part of the benefits package for national health insurance. Encourage and strengthen evidence-based decision-making through the NITAG. • Continue to investigate opportunities for procurement through UNICEF Supply Division to obtain Gavi vaccine prices. • Recognise the need to continue strengthening surveillance of NVI VPD • Ensure the continuation of rotavirus surveillance and initiation of IBD surveillance and JE • Ensure high quality Post Introduction Evaluation of all NVI.
Associated timeline	• NVI strategy development over 2018 with a view to influencing the next medium term development priorities in the health sector (2020-2024)

Technical assistance needs	• WHO, UNICEF and WB support to the development of the NVI strategy and costed scenarios. • Support to high level advocacy to other government agencies on cost/benefit and financing for NVI. • Continued discussion between UNICEF CO and SD and government on procurement through UNICEF and to obtain Gavi prices. • Possible updating of the 2004 MoU between UNICEF and government of Indonesia • Technical support to strengthening surveillance for new vaccines introductions. • Post introduction evalauation for HPV and JE . • Post SIA coverage survey for JE in Bali
Key finding 6	Governance - Coordination, collaboration, and sustainability • Note that the National Medium Term Development Plan (RPJMN) Year 2015-2019, and the associated Ministry of Health Strategic Plan and EPI cMYP are coming to the end of their planning period. • Preparations of the new medium term planning period (2020-2024) provide an opportunity for MoH with partners to influence health priorities, advocate the economic benefits of immunisation and secure financing for NVI. • Acknowledge the need for greater sub-national accountability for the operational management of the immunisation program. • Increased advocacy, partner engagement, and strategic communication at the national and subnational level. Engagement at sub-national level to build political will and leadership. Engagement across ministries - Finance, Home Affairs, Education and Culture, and Religious Affairs. • Sub national advocacy needed for sustanibility of operational cost.
Agreed country actions	Develop cMYP 2020of-2024 • Advocacy for key stakeholders at the national and subnational level
Associated timeline	• 2018/2019 making use of unspent Gavi grant funds and savings
Technical assistance needs	• Supports as identified in the revised Coverage Equity and Sustainability action plan. • Capacity building of national staff through Study tours , vaccinology course, twinning programs , exchange visits to other well performing country program

Key finding 7	Immunisation Financing • Note that the presentation from the WB provided useful recommendations to address adequacy of health sector spending at national and subnational levels, immunisation financing, service delivery at the health facility level, and the need to ensure full funding of operating costs at sub-national levels. The JA encourages discussion between the EPI unit and partners to further progress the WB recommendation. • Ensure good integration of immunization within national health insurance (JKN) and ability of new vaccines to be incorporated into the benefits package. Financing is from both national and sub-national levels, and need to ensure full funding of operating costs at sub-national levels • Note the completion of Gavi funding for HSS activities and encourage that government consider future financing to ensure a smooth transition of HSS. • Note the status of planning for polio transition and financial implications. • Note the opportunity to advocate for immunisation to be a priority and influence the upcoming Renstra and ensure financing for new vaccine introductions. • Ensure sustainable financing for VPD surveillance. • Recognise opportunities for domestic private sector resource mobilization, considering the emerging philanthropic sector and mandatory corporate social responsibility.
Agreed country actions	• Review on the integration of immunization to the JKN • Conduct advocacy to ensure sustainable financing for NVI
Associated timeline	• 2018/2019 making use of unspent Gavi grant funds and savings
Technical assistance needs	• Supports as identified in the revised Coverage Equity and Sustainability action plan.
Key finding 8	Strengthening ITAGI • Acknowledge the ITAGI's role and capacity while recognising the need to strengthen ITAGI in the area of economic analysis, administrative power and independence.
Agreed country actions	• Conduct capacity building for member of ITAGI on the area of economic analysis through training and/or site visit to the regional level • Study tour south south capacity building with other ITAGs
Associated timeline	• 2018/2019 making use of unspent Gavi grant funds and savings
Technical assistance needs	• Supports as identified in the revised Coverage Equity and Sustainability action plan.

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

Briefly describe how the Joint Appraisal was reviewed, discussed and endorsed by the relevant national Coordination Forum (ICC, HSCC or equivalent), including key discussion points, attendees, key recommendations and decisions, and whether the quorum was met. Alternatively, share the meeting minutes outlining these points.

If applicable, provide any additional comments from the Ministry of Health, Gavi Alliance partners, or other stakeholders.

8. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators			
Financial Reports			
Periodic financial reports			
Annual financial statement	HSS ✓ IPV VIG ✓ Penta VIG ✓		HPV demo ✓ JE VIG ✓
Annual financial audit report		HSS ✓ IPV VIG ✓ Penta VIG ✓	HPV demo ✓ JE VIG ✓
End of year stock level report	✓		
Campaign reports			✓
Immunisation financing and expenditure information	✓		
Data quality and survey reporting			
Annual desk review			
Data quality improvement plan (DQIP)			
If yes to DQIP, reporting on progress against it			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan		✓	
Post Introduction Evaluation (PIE)			✓
Measles-rubella 5 year plan			✓
Operational plan for the immunisation program			
HSS end of grant evaluation report	In progress		
HPV specific reports			✓
Transition Plan			✓

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

9. ANNEX B

Participants List

Participants of Joint Appraisal Workshop

A. International Partners

1 WHO
- 1 dr. Vinod Bura
- 2 Jayantha Lyanage
- 3 Fina Tans
- 4 Sidik Utomo
- 5 Rusipah
- 6 Dede Mahmuda
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- 5 Xia Wei
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- 2 Devi Aung
- 3 Laura Craw

4 Bill & Melinda Gates Foundation
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6 CHAI
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  4 Wiwitra Kahmani A
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  2 Prihatiwi Setiati

C Line Ministris

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  1 Djoko S
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  1 Suttarto

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  2 dr. Devi
3 Yayasan Abdi Dharma
  1 D.K. Yulia A.

F SKIPI - GAVI

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2 Teguh B S
3 Rizal Zaini
4 Efrika Nurma

G Others

Jakarta, 30 Mei 2018

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