



# Application Form for Human Papillomavirus Vaccine (HPV) Demonstration Programme

**Deadlines for submission of application:**

*15 January 2016*

*1 May 2016*

*9 September 2016*

**Submitted by:**

The Government of [INDONESIA]

Date of submission: [15 JANUARY 2016]

Form revised in 2015  
(To be used with Guidelines of October 2015)

The application form and attachments must be submitted in English, French, Portuguese, Spanish, or Russian.

Please ensure that the application has been received by the Gavi Secretariat on or before the day of the deadline.



## SUMMARY TABLE

Component	Country information
Date of introduction	<i>15 August of 2017</i>
Target population	<i>8984</i>
Number of districts	<i>2 Districts</i>
Vaccine preference	<i>HPV Quadrivalent (MSD)</i>
Total Budget (Year 1 + Year 2) requested from Gavi	117,051 USD
Total costs to be covered by country and/ or other partner resources	<i>46.894 USD</i>
Estimated date of national introduction	<i>TBD</i>
Programme manager/ coordinator	Dr. Prima Yosephine, MKM



## 1. APPLICATION SPECIFICATION

### 1a. Application specification

*Please specify vaccine preference.*

Preferred vaccine Bivalent (GSK) or Quadrivalent (Merck) See below for more information	Month and year of first vaccination	Preferred second presentation <sup>1</sup>
QUADRIVALENT (MSD) Vaccine	[3 <sup>rd</sup> Quarter of 2017]	BIVALENT (GSK) Vaccine

<sup>1</sup> This “Preferred second presentation” will be used in case there is no supply available for the preferred presentation of the selected vaccine (“Vaccine” column). If left blank, it will be assumed that the country will prefer waiting until the selected vaccine becomes available.

### 1b. Application specification

*Please summarise the rationale for choice of preferred vaccine. Also, please clarify whether the vaccine is licensed for use in the country*

*[Type text]*

In Indonesia, both Quadrivalent and Bivalent HPV vaccines have already been licensed by NRA and have been used in private practices.

Quadrivalent HPV vaccine is more preferred because it contains 4 serotypes of HPV 6, 11, 16 and 18 which will provide a broader protection against not only cervical cancer but also against low grade and high grade cervical and vulvar and vaginal dysplasia and external genital warts (condyloma acuminata).



For more information on WHO prequalified vaccines:

[www.who.int/immunization\\_standards/vaccine\\_quality/PQ\\_vaccine\\_list\\_en/en/index.html](http://www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/index.html)

## 2. EXECUTIVE SUMMARY

### 2. Executive Summary

*Please summarise the rationale and the expected outcome of the HPV vaccination demonstration programme Plan.*

*[Type text]*

#### EXECUTIVE SUMMARY

Immunization is a high priority program of the government of Indonesia (GoI). The government recognizes immunization as one of the most cost effective interventions contributing to the reduction of morbidity and mortality of children and thus achieving MDG target. And through its Expanded Program on Immunization (EPI), GoI has a goal to control or eliminate the morbidity and the mortality of vaccine preventable diseases. Indonesia has started the Expanded Programme on Immunization in 1977 with two antigens (BCG & DPT). Polio and

Measles were added into the program in 1980 and 1982, respectively. Indonesia achieved Universal Child Immunization (UCI) in 1990. Hepatitis B and Haemophilus influenza type B were added later into DPT to become pentavalent vaccine. Currently, the national immunization program provides BCG, DPT-HepB-Hib, OPV and Measles to children less than one year of age and TT vaccine to pregnant women throughout the country. The inactivated polio vaccine (IPV) was introduced in the province of Yogyakarta as a pilot project and will be continued as routine immunization in 2007. In line with the polio end game strategic plan, one dose of IPV will be introduced nationwide in July 2016, given to children aged 4 months, together with DPT-HB-Hib 3 and OPV4. In the National comprehensive Multi Years Plan (cMYP) 2015 – 2019, a number of new vaccines such as rubella, JE, rotavirus, HPV and pneumococcus have been planned to be introduced in this period.

The GoI has already been contributing, with payment of all routine immunization activity costs. In fact, today, all the traditional vaccines including new vaccines; HB birth dose and DTP-HB, are being fully financed by the Government with the technical support by WHO and UNICEF. Introduction of HB vaccine birth dose from 2002 to 2006 and DTP-HB-Hib/pentavalent from 2013 to 2017 was co-financed by the GoI with GAVI Alliance support.

Cervical cancer is the 2<sup>nd</sup> most common cancer among women in Indonesia and as per the ICO HPV Information Centre 2015, it is estimated to be 20,928 new cases of cervical cancer and 9,498 deaths each year. The 3 highest prevalent provinces are Yogyakarta, North Maluku, and Riau Islands with 1.5/1,000 population. Prevention and control of cervical cancer has been raised as a priority by the Ministry of Health (MoH). As such, the GoI seeks financial assistance for the HPV Demonstration Program which pilots a potentially comprehensive approach to the cervical cancer control.

It is proposed that the HPV Demonstration Program will be conducted through a school based immunization program which will be initiated in DKI Jakarta Province in 2016 with cost sharing funding between National Budget for vaccine and logistics and Local Provincial Budget for operational cost. This demo program will be continued in Yogyakarta Province in 2017 (year 1) and 2018 (year 2). The HPV demonstration program will be conducted through school based immunization program because more than 95% target is studying at primary school and technically it is expected to be easier to reach the targets. Primary education is compulsory in Indonesia. The entry age is 6 to 7 years. The net enrolment rate in primary school is 96.45% (Indonesian Health Profile 2014, MoH RI 2015).

The demonstration program will target the 5<sup>th</sup> grade primary school in 2 districts (Kulon Progo and Gunung Kidul) in Yogyakarta Province. The first dose will be administered approximately in August month each year, soon after the commencement of the new school year with interval of 12 months together with measles immunization schedule for 1<sup>st</sup> grade students in school immunization program. Eligible out of school girls (including those with a disability, migrant, marginal population) will be invited to come to Health center to receive HPV vaccination Schedule. A detailed communication strategy will be developed to sensitize the community, schools, parents, teachers, and girls prior to vaccination. The expected coverage is more than 95%.

Currently there is a well-functioning ITAGI at national level, which will be expanded to have representation from School health, RH, and Cancer program representation. In the end of year 1, of the Demonstration Programme, a convened Technical Working Group (TWG) will be formed by involving related stakeholders such as school official, education office, and gynaecologist expert, etc. The same working group will be formed in selected districts. They will meet regularly to monitor the implementation of HPV and the feasibility of incorporating the current reproductive education activities into HPV delivery in year 2.

Indonesia is committed to improve the health of women, and using the opportunity of HPV vaccine to allow delivery of other important health messages including reproductive health for this target age group. In addition, as there are currently very few screenings or treatment services for women with cervical cancer, Indonesia requests support to finalize a comprehensive cervical cancer control program over the 2 years of the demonstration program.

In 2007 (Decree of MoH no. 430, 2007) National Policy on Cancer Control was established and followed by Decree of MoH No.796, 2010 on National Policy on Cervical and Breast Cancer Control Program. Primary, secondary and tertiary preventions and treatment options were outlined. Recently, the previous decree was replaced by Regulation of ministry of health no.34 year 2015 on Breast and Cervical Cancer Control.

Currently, Indonesia has developed early detection on breast and cervical cancer which has supported by the national health insurance. This program is focus on controlling the leading cancer in Indonesia. It is consider as effective strategy to implement the early detection using Clinical Breast Examination for Breast Cancer and Visual Acetic Acid Inspection (VIA) Methods and Pap's test for cervical cancer on this program. Thus, on 21<sup>st</sup> April 2015, the first lady of Republic Indonesia has launched and endorsed this program for early detection of breast and cervical cancer for Indonesian Women. Over the course of the HPV demonstration program, the incorporation of HPV vaccine into a comprehensive national cervical cancer control program will be finalized.

This proposal has been reviewed and endorsed by the Inter-agency Coordinating Committee (ICC). Signatures of members of the ICC along with minutes of meeting are also enclosed.

### 3. IMMUNISATION PROGRAMME DATA

#### 3. Immunisation programme data

*Please provide national coverage estimates for DTP3 for the two most recent years from the WHO/UNICEF Joint Reporting Form in the table below. If other national surveys of DTP3 coverage have been conducted, these can also be provided in the table below.*

Trends of national DTP3 coverage (percentage)				
Vaccine	Reported		Survey	
Year	2013	2014	2013	2014
DTP 3	99%	[92 %]	[73 %]	[-]

#### 4. Immunisation programme data

*If survey data is included in the table above, please indicate the years the surveys were conducted, the full title, and if available the age groups the data refer to.*

**Note:** The IRC may review previous applications to Gavi for a general history of a country's capacities and challenges.

[Type text]

The *Riskesdas (Riset Kesehatan Dasar* or Basic Health Survey) was in 2013, and showed that DPT3 coverage was 73% and measles 81% at National level.

*Riskesdas/Basic Health Survey (2013) results in rural and urban population is shown in the table below:*

Characteristic	HB-0	BCG	DPT-HB3	Polio 4	Measles
Rural	85.9	91.0	79.9	80.3	84.1
Urban	71.9	83.9	71.1	73.4	80.0

## 4. HPV VACCINATION DEMONSTRATION PROGRAMME PLAN

### 4.1 District(s) profile

#### 5. District(s) profile

*Please describe which district or districts have been selected for the HPV vaccination demonstration programme, completing all components listed in the table below. Also, kindly provide a district level map of the country.*

*For further information on factors to consider when selecting the districts, please refer to Annex 2 of the HPV Demonstration Programme Guidelines.*

Component	District 1 [Kulon Progo]		District 2 (Gunung Kidul)	
	Statistic	Data Source	Statistic	Data Source
<b>Topography (% urban, % semi-urban, % rural, % remote, etc.)</b>	30% urban 70 % rural	District profile	33.33 % urban 66.75 % rural	District Profile
<b>Number and type of administrative subunits, e.g., counties, towns, wards, villages</b>	12 sub districts, 87 villages, 1 urban villages, 917 hamlets	BPS - Kulon Progo 2015	18 Sub districts, 144 villages	BPS - Gunung Kidul 2015
<b>Total population</b>	409,568 (Year 2015)	BPS - Kulon Progo 2015	725,582 (Year 2015)	BPS - Gunung Kidul 2015
<b>Total female population (%)</b>	50.15% (205,419)	BPS - Kulon Progo 2015	50.95% (369,706)	BPS - Gunung Kidul 2015
<b>Total female population aged 9-13 years by age (% of total female population)</b> <b>9 years</b> <b>10 years</b> <b>11 years</b> <b>12 years</b> <b>13 years</b>	15,567 (7,5 %) Estimated: 9 Y: 3,231 (1.5%) 10 Y: 2,906 (1.4%) 11 Y: 3,129 (1.5%) 12 Y: 3,130 (1.5%) 13 Y: 3,171 (1.5%)	BPS - Kulon Progo 2015	25,161 (6,8 %) Estimated 9 Y: 5353 (1.4%) 10 Y: 4,883 (1.3%) 11 Y: 4806 (1.3%) 12 Y: 4,959 (1.3%) 13 Y: 5,160 (1.4%)	BPS - Gunung Kidul 2015



<b>Number and type of public health facilities</b>	Public Hospital: 1 Health Center: 21	BPS - Kulon Progo 2015	Public Hospital: 1 Health Center: 30	BPS - Gunung Kidul 2015
<b>Number and type of health workers in all district public health facilities</b>	Doctor: 110 Midwife: 183 Paramedic: 511 (Including private health facilities)	BPS - Kulon Progo 2015	Doctor: 171 Midwife + Paramedic: 614 (Including private health facilities)	BPS - Gunung Kidul 2015
<b>Number and type of private health facilities</b>	Private Hospital: 7 Clinic: 7	BPS - Kulon Progo 2015	Private Hospital: 2 Maternity hospital: 3 Clinic: 152	BPS - Gunung Kidul 2015
<b>Number and type of health workers in private health facilities in the district</b>	(Included on public health facility)	BPS - Kulon Progo 2015	(Included on public health facility)	BPS - Gunung Kidul 2015
<b>Number and type of public and private primary and secondary schools</b>	Public primary: 368 Public+ Private Secondary: 78	BPS - Kulon Progo 2015	Public & Private primary: 553 Public secondary: 53 Private secondary: 48	BPS - Gunung Kidul 2015
<b>Estimate the number and percent of girls in school for each of the following ages: 9 year old girls 10 year old girls 11 year old girls 12 year old girls 13 year old girls</b>	Estimated Primary school girls: 14496 9 Y: 3,102 (14%) 10 Y: 2,790 (12%) 11 Y: 3,004 (13%) 12 Y: 3,005 (13%) 13 Y: 3,045 (13%)	BPS - Kulon Progo 2015	Estimated Primary school girls: 24,156 9 Y: 5,139 (16%) 10 Y: 4,688 (15%) 11 Y: 4,613 (15%) 12 Y: 4,761 (15%) 13 Y: 4,955 (16%)	BPS - Gunung Kidul 2015
<b>Estimate the number and percent of girls out of school for each of the following ages: 9 year old girls 10 year old girls 11 year old girls 12 year old girls 13 year old girls</b>	This is calculated based on the school attendance rate : 96% 9 Y: 129 10 Y: 116 11 Y: 125 12 Y: 125 13 Y: 126	NA	This is calculated based on the school attendance rate : 96% 9 Y: 214 10 Y: 195 11 Y: 193 12 Y: 198 13 Y: 205	NA
<b>Is any routine vaccine currently given to children using schools as delivery points?</b>	Yes (School immunization month) DT, Grade 1	Routine administrative report  Above 95% for all three	Yes (School immunization month) DT, Grade 1	Routine administrative report  Above 95% for all three

	Td, Grade 2&3 Measles Grade;1	antigens	Td, Grade 2&3 Measles Grade;1	antigens
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## 6. District(s) profile

*Please give a brief description of why this district (or districts) was (were) selected to participate in the HPV vaccination demonstration programme.*

*[Type text]*

It was decided to start the GAVI supported HPV Demonstration Programme in Kulon Progo and Gunung Kidul Districts in Yogyakarta province on Jawa Island, as the local governments in these areas have a good commitment on new programs, relative easy accessibility, dedicated human resources, good relationship between government & communities, and have experience on high immunization coverage of both traditional and new vaccines. These areas are considered as sufficient representative of the general population of Indonesia, feasible and logistically less challenging for a successful demonstration project, but still provide ample experience to allow for “learning by doing” prior to expanding nationally. Moreover, Yogyakarta province is considered as more representative of Indonesia because it has a mix composition of plain land and hilly areas, majority population are Muslim but also has other religion peoples and other cultures in both urban and rural population. Hence it is quite representative of Indonesia. Experience and lessons learnt from Year 1 and 2 will enable a higher success rate in the urban and rural areas on a small scale prior to the projected national scale up. In addition, the VIA screening is currently taking place in Kulon Progo and Gunung Kidul which will allow an impact evaluation in the coming years.

The coverage for school children immunization in Kulon Progo (99.1%) and Gunung Kidul (99.7%) are the highest among districts/cities in Yogyakarta Province. Immunization refusal rate in school children of Kulon Progo and Gunung Kidul are very low. The health centres and school officials’ participation will also strongly support the implementation of the immunization of HPV at school.

Very little migration is seen in the province especially in 2 selected districts. The province and selected districts are fairly well off.

## 7. District(s) profile

*Please describe the operations of the EPI programme in the district(s) selected for the HPV vaccination demonstration programme.*

Component	District 1 [Kulon Progo]	District 2 (Gunung Kidul)
<b>Number and type of administrative subunits (e.g. health facilities) used for routine vaccine delivery</b>	<i>Hospital &amp; Clinic: 6 Health Centres: 21 Sub Health Center: 3 Midwives: 40</i>	<i>Hospital: 1 Health Centre: 30 Sub Health Center: 28 Delivery Clinic: 85</i>
<b>Number and type of outreach sessions in a typical month</b>	All immunization services are conducted in health centres and	All immunization services are conducted in health centres and

<b>used for routine vaccine delivery</b>	sub health centres	sub health centres
<b>DTP3 coverage (including pentavalent)</b>	99.9% (2014) 100 % (2013)	98.9 % (2014) 96 % (2013)
<b>Polio3 coverage</b>	99.9 % (2014) 100 % (2013)	99.0 % (2014) 92,0 % (2013)
<b>Measles first dose coverage</b>	99.8 % (2014) 100 % (2013)	98.2 % (2014) 98.0 % (2013)
<b>Pentavalent 3 coverage</b>	Equal to DTP3 coverage	Equal to DTP3 coverage
<b>TT2+ (pregnant women)</b>	99.7 % (2014) 100 % (2013)	94.9 % (2014) 67.3 % (2013)

## 8. District(s) profile

*Please summarise the performance of the district EPI programme as reported in any recent evaluation, for example identifying resources available, management, successes, and challenges. If information from a recent effective vaccine management (EVM) assessment is available, please include.*

*[Type text]*

These selected districts have sufficient and dedicated human resource in the entire programs including immunization. All of immunization staffs have been trained. Good management on immunization program at province, district, and health centre have delivered the high coverage of routine immunization as well as new vaccines.

Successes: always reached the high coverage on routine immunization since the beginning of the program, therefore this province was not necessarily conduct the vaccination campaign which were conducted at other provinces i.e. polio and measles. Nevertheless, the challenges do occur sometimes such as vaccine refusal due to misconceptions on benefit of vaccination.

Yogyakarta province had conducted the EVM in 2011 & 2012 with a good cold chain and logistics system functional. National EVM done in 2015 also shows good capacity and well-functioning cold chain & logistics in country.

In addition, the following table summarizes the performance of these districts:

District 1: Kulon Progo	District 2: Gunung Kidul
<ul style="list-style-type: none"> <li>- All immunization officer in health centres have already been trained on Immunization services , microplanning, Cold chain, AEFI, and new vaccine introductions (Penta)</li> <li>- Vaccine storage capacity is limited, so additional cold storage is needed, plans in place to add new Cold chain equipment in 2016</li> </ul>	<ul style="list-style-type: none"> <li>- All immunization officer in health centres have already been trained on Immunization services , microplanning, Cold chain, AEFI, and new vaccine introductions (Penta)</li> <li>- Vaccine storage capacity is sufficient and all equipment's fully operational</li> </ul>

## 9. District(s) profile

Please describe any current or past linkages the district EPI programme has had with the primary and/or secondary schools or other outreach locations in the district, e.g., going to schools for health education, delivery of vaccinations, fixed routine outreaches (used by the routine immunisation programme), etc.

[Type text]

Currently, MoH of Indonesia has a National School Health Policy in coordination with Ministry of Education and Ministry of Religious Affair. One of the activities is school-based immunization month (*Bulan Imunisasi Anak Sekolah/BIAS*) beside other activities such as Personal Hygiene Behaviour, Health promotion, Reproductive Health, and Dental Hygiene. The National Socio-economic Survey (SUSENAS), a household survey conducted by the Indonesia Bureau of Statistics (BPS), found that 96.1% of children 7-12 years old were enrolled in school, compared to 79.2% for children 13-15 years old, and 49.8% for children 16-18 years old.

The reported national vaccination coverage in schools through BIAS since 2003 are about 95% each year and Yogyakarta Province 96 %. The HPV demonstration programme will be conducted at primary school targeting 5<sup>th</sup> grade school girls for both doses 12 months apart.

The National Immunization Programme (NIP) has extensive experience with successful administration of immunizations at schools and vaccination delivered to girls only. In 2009-2011, a successful national TT campaign targeted 15-45 year olds including girls attending middle and secondary schools. This included both private and public schools. The coverage of 15-45 year old females for TT3 after 3 rounds was 82%. Further provision of Td to girls in schools will be considered when assessing the feasibility of other adolescent health interventions to deliver with the HPV vaccine in year 2.

Additional information about the districts performances is listed below:

<i>District 1: Kulon Progo</i>	<i>District 2: Gunung Kidul</i>
<ul style="list-style-type: none"> <li>- Community's knowledge about immunization is good enough that make people want to vaccinate their children by going to the health facilities (health centres, sub health centres, clinics, and hospital)</li> <li>- In order to maintain its high quality, immunization service is not provided in outreach session. All is conducted in health centre or sub health centre.</li> <li>- Partnership between health officer and primary school official is very good that will support the immunization activity at school</li> </ul>	<ul style="list-style-type: none"> <li>- Community's knowledge about immunization is good enough that make people want to vaccinate their children by going to the health facilities (health centres, sub health centres, clinics, and hospital)</li> <li>- In order to maintain its high quality, immunization service is not provided in outreach session. All is conducted in health centre or sub health centre.</li> <li>- Partnership between health officer and primary school official is very good that will support the immunization activity at school</li> </ul>

## 10. District(s) profile

Please describe the potential challenges to access and deliver HPV vaccinations to girls and the ways in which these challenges will be addressed. For example, special sensitisation activities that will be done to reduce the potential for rumours.

[Type text]

The potential challenges that sometimes occur are the target doesn't attend school without any reason to avoid the vaccination, or they attend school when the vaccination is being delivered but they run out when other target is crying after the injection, or shock because of scared. Another challenge that also occurs especially at private schools is refusal of parents although less common in these two districts. The financial support such as the health officer transport cost to the school could also impede the program.

## 11. District(s) profile

*Please describe any recent studies, evaluations, or summaries of lessons learned related to socio-economic and/or gender barriers to the immunisation programme. If disaggregated vaccine coverage data by sex or wealth quintile is available from the routine immunisation programme, please note them in this section.*

[Type text]

- Gender issue does not influence the immunization program, national EPI coverage data for EPI does not have any difference in coverages by gender.
- The socio-economic barriers to administering vaccine through school-based programme are minimal because people assume that immunization is a basic requirement they must receive this. This is proven by the fact that  $\pm 60\%$  of people choose to bring their children for primary vaccination and get immunized in the private health facility (clinics, hospital) where the cost is more expensive than in health centre or sub health centre and parents are willing to pay as they realize the importance of vaccination
- Family welfare program (PKK) is proven quite optimal in increasing community's knowledge and awareness about the importance of immunization
- Nevertheless, out of school girls will be identified and invited to attend nearby school on the day of vaccination

## 4.2 HPV vaccine delivery strategy

### 12a. HPV vaccine delivery strategy

Please identify a single year of age (or single grade in school) at the target vaccination cohort within the target population of 9-13 year old girls and provide information below (see HPV Demonstration Programme Guidelines section 3.2). Countries are encouraged to use the comprehensive list of resources on HPV available at [www.gavi.org/library/documents/gavi-documents/guidelines-and-forms/hpv-resources/](http://www.gavi.org/library/documents/gavi-documents/guidelines-and-forms/hpv-resources/) to understand data sources and methods for estimating the target population in their country.

Note: The total target population for the Gavi HPV vaccination demonstration programme cannot exceed 15,000 girls per year (all districts combined). Please see section 3.2 of the HPV Demonstration Programme Guidelines for exceptions.

Countries should explicitly define the target population and where and how various subpopulations will be reached.

A preliminary estimate of the number of eligible girls in the target population for each district included in the HPV vaccination demonstration programme should be made by consulting district-level data that may be available from the national statistics office, census bureau, Ministry of Education, district health office, and education department at the district level. Countries should seek support from partners if they need assistance in making this estimate.

WHO has produced national level estimates of the 9-13 year old population by single year of age and sex for each member state. WHO, in collaboration with UNESCO, has also produced country profiles of the female 9-13 year old population in-/out-of- school by urban/rural status, and for income quintile groups. Countries are encouraged to use these estimates, as well, in informing the selection of the target population for the HPV demonstration programme.

[Type text]

This is a school based program as school attendance is high. School Immunization Program, (BIAS) all vaccines are funded by central govt and operational cost by local government. It has been operational for last 20 years and is financial sustainable. There is a multiple ministerial decree issued by Ministry of education, MOH, Ministry of internal affairs, ministry of religious affairs and clear roles and responsibilities of health workers and school teachers and other sectors. Written guidelines are available. Eligible out of school girls (including those with a disability, migrant, marginal population will be identified & invited to come to nearest Health center to get HPV vaccination (Schedule). In addition, HPV vaccine will be offered to eligible girls by inviting them to the Health Centre and the EPI outreach activity. A detailed communication strategy will be developed to sensitize the community, schools, parents, teachers, and girls prior to vaccination. The community leaders and all religion leaders will be sensitized on the importance of HPV vaccination, and they will be involved to identify & mobilize the eligible out of school-girls. Efforts are ongoing to get a Fatwa for all immunization program ( not antigen specific)

Target population Who are the girls eligible for HPV vaccine based on the criteria set by the programme?	District 1 Kulon Progo		District 2 Gunung Kidul	
	Total eligible Year 1	Total eligible Year 2	Total eligible Year 1	Total eligible Year 2
1. 5th grade primary School girls in schools	N = 3.404	N = 3455	N = 5222	N = 5299
2. Eligible out of school girls	Estimated number out of	Estimated number out of	Estimated number out of	Estimated number out of

	school girls N = ± 141	school girls N = ± 143	school girls N = ± 217	school girls N = ± 219
<b>TOTAL</b>	<b>3545</b>	<b>3598</b>	<b>5439</b>	<b>5518</b>
<b>Target for Year 1= 8984</b>				
<b>Target for year 2=9116</b>				

## 12b. HPV vaccine delivery strategy

Please describe the rationale for the choice of the target population.

[Type text]

The country will deliver HPV vaccine for 5th grade primary school students because the age suitable with the WHO recommendation which is 9 – 13 years old and technically it is expected to be easier to reach the targets. Mostly girl children in primary school are not sexually active and average age of marriage is around 20 years.

The HPV demonstration programme will be conducted at primary school targeting 5<sup>th</sup> grade school girls soon after the commencement of the new school academic year in conjunction with school immunization month of measles vaccination given to the 1<sup>st</sup> grade students. **The vaccine will be given in two doses ie 0 and 12 months)**

Data collection of the total number of 5<sup>th</sup> grade school girls in schools for HPV Demonstration Program will be completed directly to the school along with school immunization month preparatory activity.

Target age or grade Who are the eligible girls?	Year 1		Year 2	
	N. of girls	Delivery strategy	N. of girls	Delivery strategy
1. 5th grade primary school	8626	School based	8754	School based
2. Eligible out of school girls	358	Invited to school nearby	362	Invited to school nearby
3. [Type text]	[Type text]		[Type text]	
4. [Type text]	[Type text]		[Type text]	
<b>TOTAL</b>	<b>8984</b>		<b>9116</b>	

**EXAMPLE:** This may assist in defining which strategy will be used to deliver HPV vaccine with which proportion of the target population.

Countries are encouraged to use resource materials available in Annex A to learn what has been done elsewhere, and discuss and carefully select the delivery strategies that would work best in their local context.

Target age or grade	Year 1		Year 2	
	Who are the eligible girls?	N. of girls	Delivery strategy	Who are the eligible girls?
All girls attending primary school grade 5	3,000	At schools	3,300	At schools
All 10 year old girls who are not attending school at all.	250	Through mobile outreach by health workers	275	Through mobile outreach by health workers
All 10 year old girls who live in hard-to-reach villages in the mountains	500	At villages' health centre	550	At villages' health centre
<b>TOTAL</b>	<b>3,750</b>		<b>4,125</b>	

#### 14. HPV vaccine delivery strategy

Please describe the mechanism or strategy for reaching all the target girls with two doses<sup>1</sup> who were missed on the main vaccination days, specifying plans for reaching hard-to-reach or marginalized girls.

[Type text]

The student who doesn't attend school on the vaccination date will be line listed, encouraged to go the local nearby health center / Puskesmas and to be accompanied by the teacher to ensure the student get complete dose and the eligible out of school girls may be accompanied by parent or local guardian to go the nearby health center to get their dose.

<sup>1</sup> NB: Three doses are required only for those known to be immunocompromised.

#### 15a. HPV vaccine delivery strategy

Please provide a description of the process currently used to obtain (parental or guardian) consent for other vaccines given to adolescents, e.g., meningitis, hepatitis, measles, or other vaccines. Please specify whether there are any specific legal requirements for parental/guardian consent for vaccinations given to the same age group targeted for HPV vaccine delivery.

[Type text]

Before all immunization session at school, there is usually a socialization meeting or information letter sent to the parents informing about the immunization type and date. When the children attend to school during the immunization date it is considered as informed consent to get vaccinated.



## 15b. HPV vaccine delivery strategy

*Please describe the consenting procedure that will be used for HPV vaccine delivery. Specify how the parents or guardians will be informed about HPV vaccination and how they can express their willingness to allow their daughters/girls to be vaccinated or not.*

*Note: Consenting procedures should in all cases be consistent with Ministry of Health policy on consent for vaccination (see HPV Demonstration Programme Guidelines section 3.2, Year 1 programme activities, point 2).*

*[Type text]*

Consenting procedure for HPV vaccine delivery at school will be disseminated using formal letters or socialization meeting between teachers and parents to inform the vaccination schedule before the immunization activity at school. When the children attend school on the immunization date, it is considered as informed consent to get vaccinated.

## 16. HPV vaccine delivery strategy

*Please summarise ability to manage all the technical elements which are common to any new vaccine introduction, e.g. cold chain equipment and logistics, waste management, vehicles and transportation, adverse events following immunization (AEFIs), surveillance, and monitoring, noting past experience with new vaccine introductions (such as rotavirus, pneumococcal vaccine, or others).*

*Countries are encouraged to use data and information from recent post-introduction evaluations (PIE) of routine vaccine delivery to inform and provide evidence of the ability to manage the technical elements of vaccine delivery for the HPV vaccination demonstration programme.*

*[Type text]*

*An EVM assessment has been carried out in November 2015. The findings and recommendations of the assessment and improvement plan of 2015 EVM assessment is: transfer of knowledge from EPI to Pharmacy; sustainable training; temperature management; stock management discipline; supervisory support and monitoring; technical working group on EPI to include ministerial decree. Latest EVM shows that there is a good cold chain and logistic system in place. There is sufficient storage capacity for Demonstration Program of new vaccines of HPV in Gunung Kidul, but slightly limited in Kulon Progo. Plans are in place to strengthen/ supplement additional cold chain equipment through National Budget in 2016, so by the time of demonstration program starts in 2017 there will be sufficient storage capacity in both districts.*

*The National Immunization Expert recommended HPV Demonstration Program in Yogyakarta Province, which will be followed by Indonesian Technical Advisory Group on Immunization (ITAGI) recommendation. The Inter Agency Coordination Committee (ICC) endorsed HPV applications to GAVI and recommended conducting HPV Demonstration Program to 5th grade primary school in Yogyakarta Province. The HPV Demonstration Program will be followed by introduction of HPV vaccine in to routine immunization in the province. The Government of Indonesia has committed to support HPV vaccine introduction nationally*

### 17a HPV vaccine delivery strategy

Please describe the cold chain status for the selected district and the data source(s) for this information. Information such as the number of cold storage facilities, function and working order of the facilities, storage capacity (and any excess capacity), distribution mechanism for routine delivery of vaccines, status of vaccine carriers and icepacks (e.g., supply shortages or excesses), and plan for HPV vaccine storage and distribution during the HPV vaccination demonstration programme.

Component	District 1 Kulon Progo	District 2 Gunung Kidul
Number and type of cold storage facilities	21 fridges	30 fridges
Functioning and working order of the facilities	All working	All working
Storage capacity (any excess)	Sufficient	Sufficient
Distribution mechanism	National Vaccine Store distributes to Provincial main storage. Province distributes regularly to districts and then districts distribute to health centers with the cold chain equipment or vice versa	National Vaccine Store distributes to Provincial main storage. Province distributes regularly to districts and then districts distribute to health centers with the cold chain equipment or vice versa
Number and status of vaccine carriers	30 carriers	30 carriers
Number and status of icepacks (any shortages or excess)	Sufficient	Sufficient

### 17b HPV vaccine delivery strategy

Additional district cold chain information if necessary:

[Type text]

## 4.3 HPV vaccine delivery training and community sensitisation & mobilisation plans

### 18a HPV vaccine delivery training and community sensitisation & mobilisation plans

Please describe plans for training of health workers and others who will be involved in the HPV vaccination demonstration programme.

[Type text]

Training of trainers will be organized by Yogyakarta Province and assisted by central level. The training will involve provincial and district officer, teachers, education office, policy maker, community and religious leaders. The same training will be done at the district level involving health centres, local community leaders and school leaders

Training will improve the competency of staff at all levels and cover technical areas of immunization services (vaccine administration, stock management, maintenance, injection safety, AEFI identification, report and case-management, waste management, supervision, monitoring, inter personal communication, etc.). Special attention will be given to the specific characteristics of the new vaccine.

### 18b HPV vaccine delivery training and community sensitisation & mobilisation plans

**(Optional)** If available, countries may provide additional detail in the table below on training content, role, and framework.

Who will be trained	Role in vaccine delivery (e.g., sensitisation, mobilisation, immunisation, supervision, monitoring, etc.)	Training content (e.g., basics on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring, etc.)	Who will provide the training?
<b>Health workers</b>	<i>Sensitisation, mobilization, immunization, monitoring</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring	<i>Central, Province, Districts and Experts</i>
<b>Supervisors</b>	<i>Sensitization, Supervision, monitoring</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring	<i>Central, Province office</i>
<b>Teachers</b>	<i>Sensitisation, mobilization</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages	<i>Provincial, Districts, Experts</i>
<b>School officials</b>	<i>Sensitisation, mobilization</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages	<i>Provincial, Districts, Experts</i>
<b>District leaders</b>	<i>mobilization</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages	<i>Provincial, Districts,</i>
<b>Other: volunteer</b>	<i>mobilization</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages	<i>Provincial, Districts,</i>
<b>Other: cancer officer</b>	<i>Sensitization, monitoring</i>	Basic on cervical cancer, HPV, HPV vaccine, IEC messages, safe injections, AEFI monitoring	<i>Central, Province, Districts and Experts</i>

<b>Other:</b>	[Type text]	[Type text]	[Type text]
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### 19a. HPV vaccine delivery training and community sensitisation & mobilisation plans

Please describe the communication plans for sensitising and mobilising communities (e.g. girls, parents, teachers, health workers, district officials, community groups, etc.) for the HPV vaccination demonstration programme.

[Type text]

Immunization services will develop closer network with community-based organizations in order to keep permanent contact between community and health workers. In each health centre, immunization related information, education and communication will be reinforced through this network. Key messages which address parents concerns for new vaccine introduction will be disseminated to the students and parents through health workers and local medical experts.

### 19b HPV vaccine delivery training and community sensitisation & mobilisation plans

**(Optional)** If available, countries may provide additional detail in the table below on the types of information and/or materials that may be used/disseminated, to which audience, by which mechanism, and the frequency of each.

<b>Types of information or materials</b> (e.g., leaflet, poster, banner, handbook, radio announcement, etc.)	<b>Audience receiving material</b> (e.g., girls, parents, teachers, health workers, district officials, community groups, etc.)	<b>Method of delivery</b> (e.g., parent meetings, radio, info session at school, house visit, etc.)	<b>Who delivers</b> (e.g., teachers, health workers, district official, etc.)	<b>Frequency &amp; Timing</b> (e.g., daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.)
Poster/banner	Teacher, health worker, community	Health center, school	District official, health workers	two weeks before program begin
Leaflet	Girls, parents, community, teachers, health	Parents meeting, info session at school	Health workers, district official	Two weeks before program begin
[Type text]	[Type text]	[Type text]	[Type text]	[Type text]

### 20. HPV vaccine delivery training and community sensitisation & mobilisation plans

Briefly describe any potential barriers or risks to community acceptance and the process or communication plan that might be used to address this. Considerations for rumour management and crisis communication should also be described. Consider briefly describing any positive leverage points that might be beneficial for programme implementation to promote acceptability.

[Type text]

Potential barriers have been identified for HPV Vaccine are Haram( means forbidden due to religious issues) ( gender issue and AEFI issues.if any)

Risk communication strategy will be strengthened in coordination with key partners related with these issues such as community leader, religious leader, National Committee of AEFI, professional organization.

#### 4.4 HPV vaccine delivery evaluation

##### 21a. HPV vaccine delivery evaluation

Indicate the persons who will lead the coverage survey, the PIE, the costing analysis (respectively).

[Type text]

Basic Health Survey is routinely conducted by National Institute of Health Research and Development (NIHRD) every 3 years and additional independent local survey could be conducted by local universities

Costing analysis prior to the demonstration program was done by expert from NIHRD.

The coverage survey and PIE will be conducted by independent institutions from university using government budgets. While the ADH assessment will be conducted by a convened Technical Working Group (TWG) which will be formed in the first year and consist of related stakeholders such as school official, education office, and gynecologist expert, etc.

##### 21b. HPV vaccine delivery evaluation

**(Optional)** Technical partners (e.g. local WHO, UNICEF, other organisation staff) are sponsored by GAVI to offer assistance to the evaluations of HPV vaccine delivery. Please specify if these expert(s) have been identified (name, title, organization). Technical assistance can be requested through technical partners. Please refer to the Gavi PEF roster (available on the Gavi website) to identify partner TA available to you.

[Type text]

#### 4.5 Assessing potential integration of adolescent health interventions

##### 22a. Assessing potential integration of adolescent health interventions

Please summarise the anticipated activities for the assessment of integration of adolescent health interventions, such as planning milestones, stakeholder meetings, process for identifying a lead for this activity, and the process to involve the TAG in this work (see HPV Demonstration Programme

*Guidelines section 4.1 and Annex 6).*

*[Type text]*

The Immunization Sub Directorate will lead the activity School health officials, local government officials, adolescent program, and will have representation from civil society. All of issues noticed during the implementation or might occur in the future will be discussed on the TWG quarterly meeting. Any strategic/ policy issues will be discussed on the ITAG meeting or additional meeting if needed.

This group will assign a staff member to co-ordinate the collection of information to inform the selection of an intervention(s) that may be delivered with HPV vaccination. The intervention(s) will be chosen so that joint provision is unlikely to diminish whatever success the HPV vaccine program achieved in the first year.

The methods will include a desk review and key informant interviews of current interventions. The review will collate information regarding the following:

- Description of the intervention
- The evidence of effect, including programme outputs and outcomes
- Target age groups
- IEC/education materials delivered with the intervention
- Who delivers the intervention
- Personnel requirements
- Where the intervention is delivered
- Frequency of the intervention
- Locations of the intervention
- Agencies involved
- Estimation of time involvement in planning and implementing
- Training and supervision requirements
- Linkages between schools and intervention
- Factors contributing to success and barriers
- Collaborating partners
- Annual cost
- Funding source(s)
- How the intervention may promote HPV vaccine community support

## **22b. Assessing potential integration of adolescent health interventions**

**(Optional)** Countries can provide a brief summary below of the current adolescent health services or interventions and health education activities given in the district(s).

*[Type text]*

## 4.6 Development or revision of cancer control or cervical cancer prevention and control strategy

### 23a. Development or revision of cancer control or cervical cancer prevention and control strategy

Please summarise the planned activities for the development or revisions of a national cervical cancer prevention and control strategy, such as planning milestones, stakeholder meetings, methodology for developing the strategy, process for identifying a lead for this activity, and the process to involve the TAG in this work (see HPV Demonstration Programme Guidelines section 4.1 and Annex 6).

[Type text]

The revising process of existing cancer control or cervical cancer prevention by incorporating HPV vaccine lead by Cancer Subdirectorate consist of:

- a. *Revising the existing cancer prevention policy*

### 23b. Development or revision of cancer control or cervical cancer prevention and control strategy

**(Optional)** Provide a brief summary of the current cervical cancer prevention and treatment services and implementing agencies in the district selected to implement the HPV vaccination demonstration programme. If available, countries can include information on target populations, delivery structure, and funding sources.

[Type text]

## 4.7 Technical advisory group

### 24. Technical advisory group

Please identify the membership and terms of reference for the multi-disciplinary technical advisory group established that will develop and guide implementation of the HPV vaccination demonstration programme and list the representatives (at least positions, and ideally names of individuals) and their agencies (see HPV Demonstration Programme Guidelines section 4.1 and Annex 6).

Countries are encouraged to use their ICC or a subset of the ICC as the multi-disciplinary TAG.

The TAG must at least have representatives from the national EPI programme, cervical cancer prevention and control, education, the ICC (if separate from the ICC), representative(s) from adolescent and/or school health (if they are represented within the Ministry of Health), and representative(s) from civil society organisation(s) that reach the target population of 9-13 year old girls.

[Enter the family name in capital letters]

***In the current TAG Ministry of Education is not represented ,but in future expansion this will be considered***

Agency/Organisation	Name/Title	Area of Representation <sup>1</sup>
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Professor of Pediatrics (Fac. Medicine of University of Indonesia - Cipto Mangunkusumo Hospital)	Prof. Dr. dr. Sri Rezeki Hadinegoro	<i>Immunization</i>
Medical Epidemiologist	Dr. dr. Julitasari Sundoro	<i>Epidemiology</i>
Vice Chairman /Professor of Internal Medicine (Fac. Medicine of University of Indonesia –Cipto Mangunkusumo Hospital)	Prof. Dr. dr. Samsuridjal Djauzi	<i>Adult Health</i>
Professor of Internal Medicine	Prof. dr. H. Ali Sulaiman	<i>Adult Health</i>
Professor of Microbiology (Fac. Medicine of University of Indonesia –Cipto Mangunkusumo Hospital)	Prof. dr. Agus Syahrurahcman	<i>Microbiology</i>
Professor of Microbiology (Fac. Medicine of University of Indonesia – Cipto Mangunkusumo Hospital)	Prof. dr. Amin Subandrio	<i>Microbiology</i>
Professor of Pediatrics (Fac. Medicine of University of Airlangga – Soetomo Hospital)	Prof. Dr. dr. Ismoedijanto	<i>Immunization</i>
Professor of Public Health (Fac. Medicine of University of Indonesia – cipto MangunkusumoHospital)	Prof. Dr. dr. Sudarto Ronoatmodjo	<i>Epidemiology</i>
Professor of Pediatrics (Fac. Medicine of University of Padjajaran – Hasan Sadikin Hospital)	Prof. Dr. dr. Kusnandi Rusmil	<i>Immunization</i>
Professor of Pediatrics (Fac. Medicine of University of Gajah Mada – Sarjito Hospital)	Prof. dr. Sri Suparyati Soenarto	<i>Immunization</i>
Professor of Pediatrics (Fac. Medicine of University of Padjajaran – Hasan Sadikin Hospital)	Prof. dr. Cissy Kartasasmita	<i>Immunization</i>
Professor of Internal Medicine (Fac. Medicine of University of Indonesia - Cipto Mangunkusumo Hospital)	Ptof. Dr. dr. Zubairi Djoerban	<i>Adult Health</i>
Pediatrician (Fac. Medicine of University of Indonesia – Cipto Mangunkusumo Hospital)	Dr. dr. HIndra Irawan Satari	<i>Immunization</i>
Pediatrician (Fac. Medicine of University of Indonesia - Cipto Mangunkusumo Hospital)	Dr. dr. Soedjatmiko	<i>Immunization</i>
Researcher (National Institute of Health , Research and Development.	Dr. Soewarta Kosen	<i>Health Economy</i>
Pediatrician (Fac. Medicine of University of Indonesia – Harapan Kita Hospital)	Dr. dr. Toto Wisnu Hendarto	<i>Immunization</i>
Internist	Dr. Kuntjoro Harimurti	<i>Adult Health</i>



Public Health practitioner	Dr. drg. Mardiaty Nadjib	<i>Epidemiology</i>
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<sup>1</sup>Area of representation includes cancer control, non-communicable disease, immunisation, adolescent health, school health, reproductive health, maternal or women's health, cervical cancer prevention, nursing association, physicians, health communications, midwives, civil society group, education, etc.

## 25. Technical advisory group

*If known, please indicate who will act as the chair of the technical advisory group.*

*[Enter the family name in capital letters]*

	<b>Name/Title</b>	<b>Agency/Organisation</b>	<b>Area of Representation</b>
<b>Chair of Technical Advisory Group</b>	Prof. Dr. dr. Sri Rezeki Hadinegoro	Professor of Pediatrics	<i>Immunization</i>

## 4.8 Programme manager/coordinator

### 26. Programme manager/ coordinator

*List the contact details, position, and agency of the person who has been designated to provide overall coordination for the day-to-day activities of the two-year HPV vaccination demonstration programme, taking note that a technical officer/lead/manager from EPI might be most suitable as a part of their current role and responsibilities.*

*[Enter the family name in capital letters]*

<b>Name</b>	Dr. Prima Yosephine	<b>Title</b>	<i>EPI Manager</i>
<b>Tel no</b>	+62 8128096106		
<b>Fax no</b>	+62 214257044	<b>Agency</b>	<i>Sub Directorate of Immunization, DG of DC and EH</i>
<b>Email</b>	primayosephine@yahoo.com	<b>Address</b>	<i>Jl. Percetakan Negara No. 29 Jakarta Pusa</i>

## 5. TIMELINE

The HPV vaccination demonstration programme will include immunisation of the cohort of girls in two consecutive years (Figure I). Countries are required to begin vaccinating in the demonstration district(s) within two years of the application.

*Figure I. HPV vaccination demonstration programme timeline*

	Planning	Implementation Year 1 (begins first day of dose 1)			Implementation Year 2 (begins at first day of dose 1)		
Timing	Up to 8 months	Months 1-6	Months 7-9	Months 10-12	Months 1-6	Months 7-9	Months 10-12
Activities	Planning Training Supply Distribution Sensitisation Mobilisation  Orientation workshop	First year of vaccination  PIE at the time of final dose	Evaluation of Year 1  Coverage survey within 6 weeks of final dose	Meeting to review Year 1 evaluation and lessons learned  Adjust programme for Year 2  Report of Year 1 to Gavi  <b>If country is ready, prepare application for National support</b>	Second year of vaccination		Report of Year 2 to Gavi
		Costing analysis starts after the first dose					
	Assessment of adolescent health interventions			Incorporate joint delivery in programme for Year 2 (optional)	If feasible, implement joint delivery of services	If applicable, evaluate joint delivery - coverage survey & costing study	
		Start drafting cervical cancer prevention & control strategy			Completion of draft cervical cancer prevention & control strategy		Approved Cervical Cancer strategy to Gavi

## 27. Timeline

Please draft a chronogram using the Gavi chronogram template for the main activities for HPV vaccination preparations and implementation, assessment of adolescent health interventions, evaluation of the demonstration programme, and development/revision of a national cervical cancer prevention and control strategy.

Please download the Excel chronogram template from the Gavi online country portal, accessible via [www.gavi.org](http://www.gavi.org), and attach to the application form as Attachment 2.

Countries should ensure enough time is scheduled for planning activities prior to delivery of HPV1. For programme tracking purposes, Year 1 starts with delivery of the first dose of vaccine.

## 6. BUDGET

### 28. Budget

Please provide a draft budget for year 1 and year 2, identifying activities to be funded with Gavi's programmatic grant as well as costs to be covered by the country and/or other partner's resources. The budget should include costs for planning and preparations, vaccine implementation, assessment of adolescent health interventions, evaluation of the demonstration programme, and development/revision of a national cervical cancer prevention and control strategy.

Please download the Excel budget template from the Gavi website at: [www.gavi.org/support/apply](http://www.gavi.org/support/apply), and

attach to the application form as Attachment 3.

*Note: If there are multiple funding sources for a specific cost category, each source must be identified and their contribution distinguished in the budget.*

## 7. PROCUREMENT OF HPV VACCINES AND CASH TRANSFER

In the HPV Demonstration programme, HPV vaccines will be provided at no cost to the country and will be procured through UNICEF. Auto-disable syringes and disposal boxes will be provided.

Please note that, using the estimated total for the target population in the district and adding a 10% buffer stock contingency, the Gavi Secretariat will estimate supplies needed for HPV vaccine delivery in each year and communicate it to countries as part of the approval process.

### 29. Procurement of HPV vaccines and cash transfer

*Please indicate how funds for operational costs requested in your budget in section 6 should be transferred by Gavi (if applicable).*

*[Type text]*

The operational cost can be transferred to bank account of DG of DC and EH's treasury as attached in the bank form

## 8. FIDUCIARY MANAGEMENT ARRANGEMENTS DATA

### 30. Fiduciary Management Arrangements Data

*Please indicate below whether the grant to partially support the activities of the HPV vaccination demonstration programme is to be transferred to the government, or to WHO or UNICEF. Please note that WHO and/or UNICEF will require administrative fees of approximately 7% and 8% respectively which would need to be covered by the operational funds*

*If the grant for the HPV vaccination demonstration programme should be transferred to the government, countries which have completed a financial management assessment (FMA) should confirm whether the financial management modalities – including bank details – agreed with Gavi are still applicable, or alternatively provide details of any modification they intend to submit relating to the existing financial management arrangements.*

*Countries without an FMA, but who would like the grant for the HPV vaccination demonstration programme to the Government, should provide as Attachment 4 a description of their proposed funding mechanism to manage the grant for the HPV demonstration programme, covering the following processes:*

- 1. Planning, budget and coordination*
- 2. Budget execution arrangements including internal controls*

3. *Procurement arrangements*
4. *Accounting and financial reporting*
5. *External audit arrangements*
6. *Internal audit oversight*

*(Type Text)*

*Grant for the HPV vaccination demonstration programme can be transferred to the government, Indonesia already has a complete financial management assessment (FMA) – including bank details – agreed with Gavi that still applicable.*

## 9. SIGNATURES

### 9.1 Government

#### 31. Signatures

The Government of Indonesia acknowledges that this Programme is intended to assist the government to determine if and how it could implement HPV vaccine nationwide. If the Demonstration Programme shows that HPV vaccination is feasible (i.e. greater than 50% of a one-year cohort selected from the population of 9-13 year old girls in at least one district and one delivery strategy of the Expanded Programme on Immunisation (EPI)) and sustainable, Gavi will encourage and consider a national application. To ensure continuity, the application should be submitted during the first or second year of the Demonstration Programme. Application forms and guidelines for national applications are available at [www.gavi.org/support/apply/](http://www.gavi.org/support/apply/). The data from the Demonstration Programme and timing of a national application are intended to allow uninterrupted provision of vaccine.

The Government of Indonesia would like to expand the existing partnership with Gavi for the improvement the health of adolescent girls in the country, and hereby requests for Gavi support for an HPV vaccination demonstration programme.

The Government of Indonesia commits itself to improving immunisation services on a sustainable basis. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of targeted young adolescent girls with HPV vaccine as outlined in this application.

The Government of Indonesia acknowledges that some activities anticipated in the demonstration programme could be considered research requiring approval by local ethics committees (e.g., collecting data from a random sample of parents of eligible girls for the HPV vaccine coverage survey). The Government of Indonesia acknowledges responsibility for consulting and obtaining approval from appropriate local ethics committees (e.g., human subject protection committee or Institutional Review Boards) in country, as required. By signing this application, the Government of Indonesia and the TAG members acknowledge that such approval may be necessary and that it will obtain such approval as appropriate.

**The table in Attachment 3 of this application shows the amount of support requested from Gavi as well as the Government of Indonesia's financial commitment for the HPV vaccination demonstration programme.**

*Please note that this application will not be reviewed by Gavi's Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Education or their delegated authority.*

*(type text)*

MoE signature is not necessary as the school health program which also has a component of school based immunization program is currently well established and operational for last 20 years as a routine immunization program and is financial sustainable. The program has multiple ministerial decree ( legal document issued by Ministry) issued in 1998 by Minister of education, MOH, Ministry of internal affairs, ministry of religious affairs and clear roles and responsibilities of health workers and school teachers and other sectors. Under school health program there is an official policy, operational guidelines from national level for health workers and teachers, articulated roles and responsibilities for each Ministry, budget at health centre and district levels, and vaccine and supplies provided from Jakarta. BIAS covers in all public and private primary schools nationwide

MOH was assigned to coordinate and implement all school health programs . However in the planning and implementation stages both at national and sub national level officials of MoE will be involved in this Demo project.

School Immunization program evaluation document is enclosed for detailed information

Since 1998, Indonesia already have Bulan Imunisasi Anak Sekolah (BIAS), School Immunization Month Programme. This program is endorsed by the Ministries of Health, Education, Religious Affairs, and Internal Affairs launched.

This school immunization program has been implemented nationwide routinely.

## 32. Signatures

*Please provide appropriate signatures below.*

*[Enter the family name in capital letters]*

Minister of Health (or delegated authority)		Minister of Education (if social mobilization, vaccination or other activities will occur through schools) (or delegated authority)	
<b>Name</b>	Dr. Nila Farid Moeloek	<b>Name</b>	<i>[Type text]</i>

<b>Date</b>		<b>Date</b>	
<b>Signature</b>		<b>Signature</b>	

### 33. Signatures

*This application has been compiled by:*

*[Enter the family name in capital letters]*

<b>Full Name</b>	<b>Position</b>	<b>Telephone</b>	<b>Email</b>
Dr. Jane Soepardi	Director, Surveillance, Immunization and Matra Health	+62 811966169	janesoepardi@yahoo.com
Dr. Vinod K. Bura	Medical Officer, WHO EPI	+ 62 81281187429	burav@who.int
Dr. Prima Yosephine	Chief, Sub Directorate of Immunization	+62 8128096106	primayosephine@yahoo.com

## 9.2 National Coordinating Body – Inter-Agency Coordinating Committee (ICC) for Immunisation

### 34. Signatures

**We the members of the ICC, HSCC, or equivalent committee met on 13<sup>th</sup> January 2016 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.**

**The endorsed minutes of this meeting are attached as Attachment 1.**

*[Enter the family name in capital letters]*

<b>Name/Title</b>	<b>Agency/Organisation</b>	<b>Signature</b>
Dr. Untung Suseno	Secretary General	<i>[Type text]</i>
Dr. M. Subuh	Director of General of Prevention and Disease Control	<i>[Type text]</i>
Dr. Vinod Bura	WHO	<i>[Type text]</i>
Dr. Marisa Ricardo	Unicef	<i>[Type text]</i>
Dr. Roosmani	Muslimat NU - CSO	<i>[Type text]</i>
Dr. Sari Ningsih	YADJ - CSO	<i>[Type text]</i>
Meda	Perdhaki - CSO	
Dr. Toto Wisnu	ITAGI	
Dr. Hingki Satari	ITAGI	

Royani	Ministry of Finance	
Barlian	Bureau of Legal and Organization	
Dr. Anas	Planning and Budget Program and Information	
Dr. Dedy Kuswenda	Director of Health Promotion	

### 35. Programme manager/ coordinator

*In case the Gavi Secretariat has queries on this submission, please contact:*

*[Enter the family name in capital letters]*

<b>Name</b>	Dr. Prima Yosephine	<b>Title</b>	<i>EPI Manager</i>
<b>Tel no</b>	+62 214249024		
<b>Fax no</b>	+62 214257044	<b>Address</b>	<i>Jl. Percetakan Negara No. 29 Jakarta Pusat 10560</i>
<b>Email</b>	primayosephine@yahoo.com		
<b>Mobile no</b>	+628128096106		

## 10. ATTACHMENTS

**Attachment 1.** Minutes of the Inter-Agency Coordinating Committee meeting endorsing the HPV vaccination demonstration programme application.

**Attachment 2.** Chronogram for the HPV vaccination demonstration programme.

**Attachment 3.** Budget and finances for the HPV vaccination demonstration programme.

**Attachment 4.** Proposed funding mechanism for HPV vaccination demonstration programme. This is required ONLY for countries without an existing FMA and countries currently receiving Gavidirect financial support through a UN agency.