REPUBLIC OF INDONESIA

APPLICATION FOR SUPPORT TO
IMMUNIZATION SERVICES AND
NEW AND UNDER-USED VACCINES

2 MAY 2008

CONTENTS

1. Executive Summary

Indonesia is an archipelago in South East Asia with 234.8 million populations. Report shows the GNI per capita of US$ 1,260 [1], IMR of 34 per 1000 live births and Under five mortality rate of 43 per 1000 live births [2] . Expanded Program on Immunization (EPI) in Indonesia started in 1977. Immunization services in Indonesia have had a good record of past achievement; Since 1995, no poliovirus has been identified as originally from Indonesia which is in line with the global Polio Eradication Program (ERAPO). However, in 2005 -2006 Indonesia experienced an outbreak of imported Polio, 305 cases, spread in 10 provinces and 47 districts. After a series of supplementary immunization actions (SIAs) the outbreak could be controlled. The last case reported was February 20, 2006 from Aceh Tenggara district of Nanggroe Aceh Darussalam province. Since then no new case.

Acute Flaccid Paralysis (AFP) surveillance has been strengthened tremendously. Any importation of wild polio virus can be immediately identified. The system is sensitive enough to detect wild polio virus as seen from two main indicators: non polio AFP rate and specimen adequacy.

Other diseases have been controlled but require more effort to reduce their occurrence. Even though immunization program performs well, it has not yet reached its full potential as there are still cases of vaccine preventable diseases in some areas.

The goal of NIP in Indonesia is to reduce morbidity and mortality due to vaccine preventable diseases through eradication, elimination or reduction. With over 200 million people, Indonesia annually has to immunize around 4.6 million children surviving to the age of one year. Seven basic vaccines are administered to these children as a national policy: BCG, DTP, Polio, Measles and Hepatitis B.

Neonatal tetanus, maternal tetanus and measles have also been a problem in Indonesia and the GOI has adopted Neonatal and Maternal Tetanus Eradication (MNTE) and Measles Reduction Efforts (REDCAM) to reduce the spread of these diseases. The GOI has been promoting some strategic campaign activities, including MNTE, measles crash program, school base measles campaign and other activities to scale up the process of reducing the number of cases or even to eliminate them. In 2007, the number of Diphteria cases is 164 cases (national level), East Java has the highest number of cases with 87 cases (in 17 districts), was increased from 43 cases in 2006 (in 13 districts).

Immunization coverage is increasing and the achievement as of 2005 (cMYP base year) is:

- UCI villages 76.2%
- Coverage (routine) 76.4% DTP3
- Measles coverage 86.7%
- TT2 + for pregnant women 57%
- MNT high risk districts: 63 districts our of 440 districts

The achievement for the year 2007: (base on routine report)

- UCI villages 71.7% (received from 28 out of 33 provinces, as of 1 May 2008)
- Coverage (routine) DTP3 89.9%
- Measles coverage 89.2%
- TT2 + for pregnant women 78%

Decentralization and political reform in the late 1990s affected the sustainability of availability funding for immunization. The central level is responsible for supplementary immunization

[1] World Bank (forthcoming)

[2] Population Reference Bureau and WHO

activities, procurement of vaccines and syringes, technical assistance, development of guidelines, monitoring and evaluation, quality control and training. District governments now take responsibility for their immunization programs, to provide operational/ handling cost.

The Strategic comprehensive Multi-Year Plan (cMYP) for the National Immunization Program (NIP) has been developed for 2007-2011 based on GIVS guidelines (the base year is 2005). The plan is in line with Strategic Plan of MOH, its vision, mission, and 4 strategic pillars. The plan is also corresponds to the GAVI Alliance goals for 2006-2011.

The National Immunization Program's goals and objectives will focus on the following priority targets:

- To achieve UCI village 92% (coverage of measles minimum 80%) by the end of 2007, and 100% UCI in villages by the year 2010
- To achieve 80% *Hep-B Birth dose* (HB-0 for newborn < 7 days) by 2010
- To provide immunization Hep-B (1-3) and DPT using combo vaccine in 2007
- To achieve coverage of Measles second dose $\geq$ 95% school age children
- To maintain use of AD syringes 100%
- To develop national policy on waste management in 2008 and ensure all waste derived from vaccines comply with that standard by the year 2010
- To eradicate polio by 2010
- To eliminate MNT (incidence rate < 1 per 1000 live births in every district) in 2010
- To reduce annual measles death by 90% in 2010 from 2000 estimates
- To introduce JE vaccines at selected areas in 2009 , Hib in year 2010 and Pneumoccoccal vaccines in year 2011

Immunization Service Support (ISS)

The ISS proposal to GAVI is calculated based on national projection figures and provincial estimate. The JRF figure in 2007 showed that the EPI covered DTP3 as of 4,415,140 out of targeted 4,875,006 children. This population target is calculated from consolidate provincial estimate and reports. (Provinces have their own population target estimate, other than the SUPAS which was used on estimation in cMYP)

As per milestones set in the cMYP, the GOI is committed to increase the coverage for all routine antigens to 100% to correspond with the vision of the MOH to achieve village UCI 100% by the year 2010. The GAVI-ISS funds have been very supportive for EPI to achieve its goal.

For this second phase, the ISS funds will be used to continue activities carried out in the previous phase, as well as efforts to reach the un-reach/ underserved areas. Strategies and activities are identified and in line with budget and time line, including advocacy and social mobilization. The DQS, EVSM and coverage surveys will be conducted routinely. Training staffs will also be undertaken to strengthen data management and monitoring at all level (recording and reporting and LAM). The activities will involve private sectors.

Channeling GAVI funds will follow GOI regulation (all foreign grants must be written in the national budget document). Activities will be done in accordance with cMYP. With the flexibility of uses of funds, the gap in the plan will be filled by the ISS funds. DG of DC and EH is responsible for payment authorization.

Estimate of fund expected from ISS (US $)

	Base 2005	Year 2007	Year 2008	Year 2009	Year 1 2010	Year 2 2011
DTP/HB 3 Coverage rate		90.5%	95%	100%	80%	50%
DTP/HB/Hib 3 Coverage rate		0	0	0	20%	50%
Number of infants reported / planned to be vaccinated with DTP-HB3 (as in Table 3.4)				4,782,467	4,844,639	4,907,619
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP-HB3				297,450	62,172	62,980
Funds expected ($20 per additional infant)				5,949,000	1,243,440	1,259,600

2. Signatures of the Government and National Coordinating Bodies

Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Indonesia would like to expand the existing partnership with the GAVI Alliance for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests for GAVI support for ISS, New –under-used vaccines

The Government of Indonesia commits itself to developing national immunisation services on a sustainable basis in accordance with the comprehensive Multi-Year Plan presented with this document. The Government requests that the GAVI Alliance and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table N° 6.5.1 and 6.5.2 of page 21 and 23 of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. Table N° 6.4.1 and 6.4.2.of page 20-21 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

“Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of April. The payment for the first year of co-financed support will be around April 2010 (specify month and year).”

Ministry of Health:
Title : Director of Surveillance Epidemiology, Immunization and Matra Health

Signature:

Name: Dr. H. Andi Muhadir, MPH

Date : May 2, 2008

Ministry of Finance:

Signature: ……

Name: ……

Date: ……

National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation:

We the members of the ICC/HSCC[3] met on the 2nd May 2008 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 DOCUMENT NUMBER:

Name/Title	Agency/Organisation	Signature

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

Name: Dr. Carmelia Basri, Mepid Title: EPI Manager

Tel No.: 62 21 4249024 Address: Jln Percetakan Negara No. 29

Fax No.: 62 21 4257044 Jakarta

Email: carmeliabasri@yahoo.com Indonesia

The GAVI Secretariat is unable to return documents and attachments to individual countries. Unless otherwise specified, documents may be shared with the GAVI partners and collaborators.

The Inter-Agency Coordinating Committee for Immunisation

Agencies and partners (including development partners and CSOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC/HSCC). The ICC/HSCC are responsible for coordinating and guiding the use of the GAVI ISS and NVS support. Please provide information about the ICC/HSCC in your country in the spaces below.

Profile of the ICC/HSCC

Name of the ICC/HSCC: Inter-agency Coordinating for Implementation of Immunization in Indonesia

Date of constitution of the current ICC/HSCC: 16 December 2004, Decree of the Minister of Health, DR dr. Siti Fadilah Supari, Sp.JP(K) No. 1274/MENKES/SK/XII/2004

Organisational structure (e.g., sub-committee, stand-alone):

- Stand alone
- ICC responsible to Minister of Health
- ICC report to Minister of Health

Chairman : Minister of Health

[3] Inter-agency coordinating committee or Health sector coordinating committee, whichever is applicable.

Frequency of meetings: plan for every 3 month

Composition: Government, International Partners, CSOs,

Function	Title / Organization	Name
Chair	Minister of Health	DR. dr. Siti Fadilah Supari SpJP(K)
Members	• WHO Representative to Indonesia • UNICEF Representative to Indonesia • UNDP Representative to Indonesia • Resident Repr, The World Bank, Jakarta • Resident Repr, Asian Development Bank, Indonesia • Director, Pop. Health & Nutrition, USAID, Jakarta • Australian Team Leader AusAID in Indonesia • Director of KFW Office, Jakarta • Resident Repr. Japan Inter.Coop Agency (JICA) • Embassy of Canada, Program Officer CIDA, Jakarta • Embassy of Canada, Program Officer CIDA, Jakarta • Pres.Director PT Biofarma, Bandung • Governor Rotary Int. District 3400, Jakarta • Site Manager of PATH Jakarta	

Major functions and responsibilities of the ICC/HSCC:

1. Gives inputs to the Ministry of Health for developing national policy on immunization
2. Support the Ministry of Health to mobilize international source of fund and private fund in supporting immunization program
3. Give technical assistance to strengthen immunization program
4. Together with the Ministry of Health conduct evaluation of the implementation of immunization program
5. Support the Ministry of Health in developing the Long term and Middle term Plan for EPI

Three major strategies to enhance the ICC/HSCC's role and functions in the next 12 months:

1. Most of the ICC members active in the Technical Working Groups coordinated by WHO. The TWG conduct meetings and discussion regularly, reviewing progress and advice on the policy and strategies relating to the EPI
2. Periodically supervise and monitor the implementation of EPI and the GAVI support
3. Oversee and review the preparation and annual progress report to GAVI alliance

3. Immunisation Programme Data

Please complete the tables below, using data from available sources. Please identify the source of the data, and the date. Where possible use the most recent data, and attach the source document.

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (or equivalent plan), and attach a complete copy (with an executive summary) as DOCUMENT NUMBER 1
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms on Vaccine Preventable Diseases and attach them as DOCUMENT NUMBERS 2 & 3
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

Table 3.1: Basic facts for the year 2008 (the most recent; specify dates of data provided)

	Figure	Date	Source
Total population	234.8 m[4]	2008	Population (2008 projection) calculated from Population Reference Bureau (www.prb.org)
Infant mortality rate (per 1000)	34/1000	2007	PRB
Surviving Infants*	4,721,092	2008	cMYP
GNI per capita (US$)	US$ 1,260	2007	WB: Health Public Expenditure Review (forthcoming)
Percentage of GDP allocated to Health	2.8%	2004	World Health Statistics 2007
Percentage of Government expenditure on Health	5,0%	2007	WB : Health Public Expenditure Review (forthcoming)

* Surviving infants = Infants surviving the first 12 months of life

Please provide some additional information on the planning and budgeting context in your country:

Please indicate the name and date of the relevant planning document for health.
National Health Strategic Plan 2004 – 2009, revised and reissued in May 2006

Is the cMYP (or updated Multi-Year Plan) aligned with this document (timing, content etc)?
Yes

Please indicate the national planning budgeting cycle for health.
Annual plan : January - December
Please indicate the national planning cycle for immunization
Annual plan : January – December

[4] PRB data. This figure is higher than cMYP since cMYP has projected based on 2005 figures

Table 3.2: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement *(refer to cMYP pages)*

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Comments**
		Entire country	**Only part of the country**	
HepB 0, BCG, OPV1	0 months 1 months	X		
DTP/HB1, OPV2	2 months	X		
DTP/HB2,OPV 3	3 months	X		
DTP/HB3, OPV4	4 months	X		
Measles	9 months	X		
JE	9 months		X	Only in JE endemic province that after completed campaign
IPV 1-4	0-4 months		X	Only in one province of Yogyakarta (pilot project)
Vitamin A	> 6 months	X		Two rounds in a year (Feb and August)

Table 3.3: Trends of immunization coverage and disease burden
(as per last two annual WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases)

Trends of immunisation coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Survey**		**Disease**	**Number of reported cases**	
		2006	**2007**	**2002/03**	**2007…**		**2006**	**2007**
BCG		91	94.1	82%		Tuberculosis*	397	25,293
DTP	DTP1	91	11.7%	80%		Diphtheria	432	164
	DTP3	85	11%**	55%		Pertussis	7,581	0
DTP/HB 1			83.9%	NA		Hep B	1,727	10
DTP-HB3			79.6%	NA		Polio	2	0
Measles (first dose)		85	89.2	63%		Measles	20,422	15,125
TT2+ (Pregnant women)		54	82.6	NA		NN Tetanus	118	125
Hib3			NA	NA		Hib	NA	NA
Yellow Fever		NA	NA	NA	NA	Yellow fever	NA	NA
HepB3				NA		hepB sero-prevalence	NA	NA
Vit A supplement***	Mothers (<6 weeks post-delivery)	56.39	47.4					
	Infants (>6 months	77.58	83.21					
	Children (>12-59 months)	86.95	87.24					

* Source : TB Program DC & EH, MOH . Data for 2006 is obtained from 2 provinces and 2007 from 17 provinces (children only).
** DTP3 total coverage is 79% + 10.9% = 89.9%
*** Source : Directorate of Nutrition, MOH

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 refers to:

DHS survey was conducted for the year 2002-2003. The age group the data refers is children 12-23 months. Coverage survey 2007 is still in the process of report writing, will be published by the end of May 2008

Table 3.4: Baseline and annual targets

Number		Baseline and targets				
		Base Year (2007)	**Year 2008**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**
Births		4.875.006	4,938,381	5,002,580	5,067,614	5,133,493
Infants' deaths		214,500	217,289	220,114	222,975	225,874
Surviving infants		4,660,506	4,721,092	4,782,467	4,844,639	4,907,619
Pregnant women		5,362,507	5,432,219	5,502,838	5,574,375	5,646,842
Target population vaccinated with BCG		4.875.006	4,938,381	5,002,580	5,067,614	5,133,493
BCG coverage*		95%	95%	98%	100%	100%
Target population vaccinated with OPV3		4,427,480	4,485,038	4,686,817	4,844,639	4,907,619
OPV3 coverage**		95%	95%	98%	100%	100%
Target population vaccinated with DTP-HB 3***		4,427,480	4,485,038	4,782,467	3,875,711	2,453,809
DTP-HB3 coverage**		95%	95%	100%	80%	50%
Target population vaccinated with DTP-HB1***		4,660,506	4,721,092	4,782,467	4,844,639	4,907,619
Wastage[5] rate in base-year and planned thereafter		1.43	1.43	1.33	1.33	1.33
Target population vaccinated with **3rd dose** of DTP-HB-HIB3……		0	0	0	968,928	2,453,809
……. Coverage**		0	0	0	20%	50%
Target population vaccinated with **1st dose** of DPT-HB-HIB……..		0	0	0	968,928	2,453,809
Wastage[1] rate in base-year and planned thereafter		0	0	1.05	1.05	1.05
Target population vaccinated with **1st dose** of Measles		3,728,405	4,012,928	4,304,220	4,602,407	4,907,619
Target population vaccinated with **2nd dose** of Measles		4,223,191	4,400,682	4,456,246	4,507,340	4,559,020
Measles coverage 1st dose**		80%	85%	90%	95%	100%
Pregnant women vaccinated with TT+		5,362,507	5,432,219	5,502,838	5,574,375	5,646,842
TT+ coverage****		100%	100%	100%	100%	100%
Vit A supplement	Mothers (<6 weeks from delivery)	NA	NA	NA	NA	NA
	Infants (>6 months)	NA	NA	NA	NA	NA

[5] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check **table α** after Table 7.1.

	Children (> 12 -59 months	NA	NA	NA	NA	NA
	Annual DTP Drop out rate [(DTP1 - DTP3)/DTP1] x100	NA	NA	NA	NA	NA
	Annual Measles Drop out rate (for countries applying for YF)	NA	NA	NA	NA	NA

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

Table 3.5: Summary of current and future immunisation budget *(or refer to cMYP pages)*

	Estimated costs per annum in US$ (,000)				
Cost category	**Year 2007**	**Year 2008**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**
Routine Recurrent Cost					
Vaccines (routine vaccines only)					
Traditional vaccines	13,128,864	12,902,058	10,785,316	10,601,118	10,606,108
New and underused vaccines	20,909,692	21,181,518	22,622,351	31,087,317*	57,559,234*
Injection supplies	8,230,126	8,357,239	8,170,945	8,307,872	8,670,566
Personnel					
Salaries of full-time NIP health workers (immunisation specific)	865,522	904,073	936,071	974,745	1,010,907
Per-diems for outreach vaccinators / mobile teams	6,809,305	7,847,354	8,923,899	10,040,552	10,357,333
Per-diems for supervision & monitoring	1,465,025	1,570,667	1,664,942	1,782,192	1,886,674
Transportation	2,590,589	2,646,405	3,357,181	4,096,184	4,862,789
Maintenance and overheads	7,154,297	8,934,790	10,010,743	8,396,137	10,392,873
Training	2,096,269	2,138,195	2,180,958	2,224,578	2,269,069
Social mobilisation and IEC	1,409,611	1,437,804	1,637,987	2,011,753	2,901,037
Disease surveillance[6]	-	-	-	-	-
Program management	2,244,727	2.289.622	2,335,414	2,382,122	2,429,765
Other	10,338,612	10.422.179	10,630,622	10,843,235	11,190,846
Subtotal Recurrent Costs	**77,242,640**	**80,631,903**	**83,256,429**	**92,747,804**	**124,137,201**
Routine Capital Costs					
Vehicles	9,019	1,147,506	13,310,676	13,599,678	6,180,296
Cold chain equipment	37,737,992	26,689,803	13,766,666	26,933,174	31,267,260
Other capital equipment	5,732,679	454,491	463,580	794,733	571,798
Subtotal Capital Costs	**43,479,690**	**28,291,800**	**27,540,922**	**41,327,585**	**38,019,354**
Campaigns					

[6]NA (Excluded), managed by different unit

Polio	7,710,782	-	-		
Measles	23,338,391	-	-		
Yellow Fever	-	-	-		
MNT campaigns	-	1,805,573	2.761.324		
JE			1,154,309		
Subtotal Campaign Costs	**31,049,173**	**1,805,573**	**3,915,633**		
Other costs	**28,271,735**	**29,965,587**	**32,619,556**	**35,283,661**	**36,406,203**
GRAND TOTAL	**180,043,237**	**140,694,863**	**147,332,541**	**169,359,050**	**198,562,757**

*Underused vaccine 2010 and 2011 including JE funded by GOI

Please list in the tables below the funding sources for each type of cost category (if known). Please try and indicate which immunisation program costs are covered from the Government budget, and which costs are covered by development partners (or the GAVI Alliance), and name the partners.

Table 3.6: Summary of current and future financing and sources of funds *(or refer to cMYP)*

		Estimated financing per annum in US$ (,000)				
Cost category	**Funding source**	**2007**	**2008**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**
Routine Recurrent Cost						
Vaccines (routine vaccines only)						
1. Traditional vaccines	Government	13,128,864	12,902,058	10,785,316	10,601,118	10,606,108
2. New and underused vaccines[7]	Government	20,909,692	21,181,518	22,622,351	31,087,317	57,559,234
Pentavalent and Pneumoccoccal (to be discussed further)	GAVI				8,238,000	35,097,753
3. Injection supplies	Government and donor	8,357,239	8,170,945	8,307,872	8,670,566	8,230,126
Injection supplies (Hib) proposed to GAVI (to be discussed further)	GAVI				299,777	673,700
Personnel						
4.Salaries of full-time NIP health workers (immunisation specific)	Government	865,522	904,073	936,071	974,745	1,010,907
5. Per-diems for outreach vaccinators / mobile teams	Government and donor	6,809,305	7,847,354	8,923,899	10,040,552	10,357,333
6. Per-diem for supervision & monitoring	Governemt and donor	1,465,025	1,570,667	1,664,942	1,782,192	
7. Transportation	Government	2,590,589	2,646,405	3,357,181	4,096,184	4,862,789
8. Maintenance and overheads	Government	7,154,297	8,934,790	10,010,743	8,396,137	10,392,873
9. Training	Government and donor	2,096,269	2,138,195	2,180,958	2,224,578	2,269,069
10. Social mobilisation and IEC	Government and donor	1,409,611	1,437,804	1,637,987	2,011,753	2,901,037
11. Disease surveillance[8]		-	-	-	-	-
12. Program management	Government	2,244,727	2.289.622	2,335,414	2,382,122	2,429,765

[7] New and underused vaccines include Uniject HB, DPT/HB, JE vaccines

[8] NA, managed by other unit

* started in 2009 DTP/HB/HIb (pentavalent) is planned to be included in phases to routine EPI , to replace DTP/HB (tetravalent)

13. Other	Government	10,338,612	10.422.179	10,630,622	10,843,235	11,190,846
Routine Capital Costs						
1. Vehicles	Government	9,019	1,147,506	13,310,676	13,599,678	6,180,296
2. Cold chain equipment	Government and donor	37,737,992	26,689,803	13,766,666	26,933,174	31,267,260
3. Other capital equipment	Government and donor	5,732,679	454,491	463,580	794,733	571,798
Campaigns						
1. Polio	Government and donor	7,710,782	-	-		
2. Measles	donor	23,338,391	-	-		
3. Yellow Fever	NA	-	-	-		
4. MNT campaigns	donor	-	1,805,573	2.761.324		
5. JE	Government and donor			1,154,309		
Other costs	Government	28,271,735	29,965,587	32,619,556	35,283,661	36,406,203
GRAND TOTAL		**178,096,437**	**138,742,110**	**145,393,136**	**166,991,608**	**194,825,904**

4. Immunisation Services Support (ISS)

Please indicate below the total amount of funds you expect to receive through ISS:

Table 4.1: Estimate of fund expected from ISS (US $)

	Base 2005	**Year 2007**	**Year 2008**	**Year 2009**	**Year 1 2010**	**Year 2 2011**
DTP/HB 3 Coverage rate		90.5%	95%	100%	80%	50%
DTP/HB/Hib 3 Coverage rate		0	0	0	20%	50%
Number of infants reported / planned to be vaccinated with DTP-HB3 (as in Table 3.4)				4,782,467	4,844,639	4,907,619
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP-HB3				297,450	62,172	62,980
Funds expected ($20 per additional infant)				5,949,000	1,243,440	1,259,600

If you have received ISS support from GAVI in the past, please describe below any major lessons learned, and how these will affect the use of ISS funds in future.

Please state what the funds were used for, at what level, and if this was the best use of the flexible funds; mention the management and monitoring arrangements; who had responsibility for authorising payments and approving plans for expenditure; and if you will continue this in future.

Major Lessons Learned from Phase 1	Implications for Phase 2
1.Funds were used for coordination, planning-evaluation meetings, strengthening LAM in health center, sweeping, supervision and monitoring. Supervisions have been done by central level to province as well as province to districts and district to health center. ISS funds were used as supplementary to Government's funds, to strengthen routine immunization, aiming at increasing coverage of DPT3. Local Government contribution was low, need more advocacies. Old cold chain equipments in some districts need replacement.	For the second phase, the ISS funds will be used to: • continue activities carried out in the previous phase, • reach the un-reach/ underserved areas. • Strategies and activities are identified and in line with budget and time line, including advocacy and social mobilization.
2. Funds were also used for training staffs (on safety injection, DQS, EVSM). Limitation of technical staffs especially in new provinces, districts and health center was found. Self-assessment on data quality (DQS) has been done in 6 provinces, some have been done by central level and some assessment done by provincial level	The ISS funds will also be used to • conduct DQS, EVSM and coverage surveys routinely. • Train staffs to strengthen data management and monitoring at all level (recording and reporting and LAM), including private sectors .
3. Most of the ISS supported activities were focused at sub-national level	The next phase will also be focusing the activities at province, district and health center level
4. Monitoring –evaluation was done from central level down to province, province to district and district down to health center. Some problems on safety injection, cold chain and vaccine management remain.	Monitoring and evaluation will be carried out by all levels: central, province, districts, including to monitor incidence of VPD and outbreak. By strengthening staffs at sub-national level, as well as developing new RR covers new vaccine and on the job training, improved monitoring-evaluation is expected to be achieved
5. Financial arrangement was set up according to GOI central budget procedures Flexibility in use of funds made easier for implementation of immunization activities.	Channeling GAVI funds will follow GOI regulation (all foreign grants must be written in the national budget document). Activities will be done in accordance with cMYP. With the flexibility of uses of funds, the gap in the plan will be filled by the ISS funds. DG of DC and EH is responsible for payment authorization.

5. Documents required for each type of support

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form (last two)	1	2006 -2007
ALL	Comprehensive Multi-Year Plan (cMYP)	2	2007 -2011
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed	3	2008
ALL	Endorsed minutes of the ICC/HSCC meeting where the GAVI proposal was discussed	4	2008
ALL	Minutes of the two most recent ICC/HSCC meetings	5	2007
ALL	ICC/HSCC workplan for the forthcoming 12 months	6	2008
Injection Safety	National Policy on Injection Safety including safe medical waste disposal (if separate from cMYP)	NA	
Injection Safety	Action plans for improving injection safety and safe management of sharps waste (if separate from cMYP)	NA	
Injection Safety	Evidence that alternative supplier complies with WHO requirements (if not procuring supplies from UNICEF)	NA	
New and Under-used Vaccines	Plan for introduction of the new vaccine (if not already included in the cMYP)	NA	

** Please indicate the duration of the plan / assessment / document where appropriate*

ANNEX 1

Banking Form

SECTION 1 ***(To be completed by payee)***

In accordance with the decision on financial support made by the GAVI Alliance dated . . . . . , the Government of . . . . . hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: *(Account Holder)*		
Address:		
City – Country:		
Telephone No.:	**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**
For credit to: ***Bank account's title***		
Bank account No.:		
At: ***Bank's name***		

Is the bank account exclusively to be used by this program? **YES ( ) NO ( )**

By whom is the account audited? .....

Signature of Government's authorizing official:
By signing below, the authorizing official confirms that the bank account mentioned above is known to the Ministry of Finance and is under the oversight of the Auditor General.

Name:	.....	**Seal:**
Title:	.....	
Signature:	.....	
Date:	.....	
Address and Phone number		
Fax number		
Email address:		

SECTION 2 ***(To be completed by the Bank)***

FINANCIAL INSTITUTION		CORRESPONDENT BANK (*In the United States)*
Bank Name:		
Branch Name:		
Address:		
City – Country:		
Swift code:		
Sort code:		
ABA No.:		
Telephone No.:		
Fax No.:		
Bank Contact Name and Phone Number:		

I certify that the account No. . . . . is held by *(Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name: ..... **Title:**	**Signature:** ..... **Date:** .....
2 Name: ..... **Title:**	**Seal:**
3 Name: ..... **Title:**	
4 Name: ..... **Title:**	

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI Alliance – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais des Nations
CH 1211 Geneva 10
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....