Application Form for Gavi NVS support

Submitted by

The Government of

Indonesia

Date of submission: **18 January 2016**

Deadline for submission:

i. **19 January 2016**
ii. 1st May 2015
iii. 9 September 2015

Select Start and End Year of your Comprehensive Multi-Year Plan (cMYP)

Start Year	2015	End Year	2019

Form revised in 2015

(To be used with Guidelines of November 2015)

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

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application.The Gavi will document any change approved by the Gavi, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the Gavi all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the Gavi, within sixty (60) days after the Country receives the Gavi's request for a reimbursement and be paid to the account or accounts as directed by the Gavi.

SUSPENSION/ TERMINATION

The Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any Gavi-approved amendment to the application.The Gavi retains the right to terminate its support to the Country for the programmes described in its application if a misuse of Gavi funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland

. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The Gavi will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

1. Type of Support requested

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
Preventive Campaign Support	JE, 5 dose(s) per vial, LYOPHILISED	2017	2017	
	If the selected vaccine is not your 1st preference, please state your preferred vaccine and presentation			If the selected vaccine is not your 1st preference, please state your preferred vaccine and presentation
Preventive Campaign Support	MR, 10 dose(s) per vial, LYOPHILISED	2017	2017	

[1] Gavi may not be in a position to accommodate all countries first product preferences, and in such cases, Gavi will contact the country and partners to explore alternative options. A country will not be obliged to accept its second or third preference, however Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine. If a country does not indicate a second or third preference, it will be assumed that the country prefers to postpone introduction until the first preference is available. It should be noted that this may delay the introduction in the country.

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3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign :
  - The duration of support
  - The total amount of funds requested
  - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
  - Projected month and year of introduction of the vaccine (including for campaigns and routine)

- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population from Risk Assessments from Yellow Fever and Meningitis A
  - Birth cohort, targets and immunisation coverage by vaccines

- Country preparedness
  - Summary of planned activities to prepare for vaccine launch, including EVM assessments, progress on EVM improvement plans, communication plans, etc.
  - Summary of EVM assessment and progress on EVM improvement plan

- The nature of stakeholders' participation in developing this proposal
  - Inter-Agency Coordinating Committee
  - Partners, including CSO involvement

The Indonesian National Health Development Program is based on a primary health care systems concept: the community health center is the basic health care facility, supported by hospitals and other community-based health care facilities. The Ministry of Health (MoH) has overall responsibility for the nation's health care policy. It manages and operates health care programs, including staffing, education and training, and health services for more than 17,000 islands spread over 1.9 million square kilometers and home to some 230 million people. Its population is characterized by its wide diversity: demographic, economic, social, political, and cultural. About 50.2 percent of the population lives in rural areas

Immunization is a high priority program of the government of Indonesia. 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 / SDG target.Indonesia has made steady and significant improvements in child-health but facing setbacks in reducing maternal mortality.Health workers are one of the key building blocks of a country’s health system, as well as the economy more broadly

Infants and young children receive basic immunizations from various personnel in several venues, including the Integrated Service Post (Posyandu) managed by staff from the community (cadre), the village maternity clinics (polindes/poskesdes) managed by the village midwife (bidan desa), the health centers, and government and/or private hospitals. At Posyandu , immunization is key part of services at community level beside other activities include child growth monitoring , ANC, health education etc. During the first visit, each child receives a health card (KMS, Kartu Menuju Sehat). During the mother’s first ANC visit, she reeives a maternal and her child health book (Buku KIA/Kesehatan Ibu dan nak), which is used to record basic information of the mother and her child. The informatio about child’s immunization is recorded.

In Indonesia, the Expanded Programme on Immunization started in 1977 with two antigens (BCG & DPT). Polio and measles were added into the program in 1980 and 1982, respectively. In 1990 Indonesia achieved Universal Child Immunization (UCI). Hepatitis B was added to DPT to become tetravalent vaccine in 2006 and Haemophylus influenza type B was added into DPT-HB to become pentavalent vaccine (DPT-HB-Hib) in 2014. 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 is continued as routine immunization replacing OPV until now. In line with the polio end game strategic plan,

Indonesia will switch from trivalent OPV (tOPV) to bivalent OPV (bOPV) in April 2016, and one dose of IPV will be introduced in July 2016 nationally, to be given to children aged 4 months, together with DPT-HB-Hib 3 and OPV4.

The World Health Assembly (WHA) was endorsed the Global Vaccine Action Plan (GVAP) of the decade of vaccines in May 2012. One of the four high level goals of GVAP was to meet the global and regional elimination targets to achieve elimination in at least 5 regions including SEAR country by 2020. Indonesia had committed to achieve measles elimination and rubella/CRS control by 2020 including in comprehensive Multi Year Plan of immunization 2015 to 2019 and National Measles Rubella Strategic Plan 2015-2020.

In Indonesia National Comprehensive Multi Year Immunization Plan (cMYP) 2015 – 2019, a number of new vaccines, such as rubella, JE, HPV, rotavirus, pneumococcus, have been planned to be introduced in the period . Country has a strong NTAGI independent body to advise EPI progrms on NVI. Indonesia also has a robust AEFI surveillance system in place, hence any new vaccine introduction safety issues can be closely monitored. The cold chain capacity & logistics suply chain is quite good and hence JE/MR and HPV demo introductions will not have any significant load on existing Cold chain capacity, which is also being expanded further.

Indonesia is applying for GAVI support towards

- **JE :** 24 countries in the WHO South-East Asia and Western Pacific regions have JEV transmission risk, which includes more than 3 billion people, this aslo includes Indonesia..Prior to 2006, JE data in Indonesia were mostly based on a number of studies conducted in a number of places. All of those studies revealed, that there are evidences that JE is endemic in Indonesia. However, since 2006 there have been no JE particular studies conducted, Supported by WHO , an initiative to develop JE surveillance on a more routine purpose was re-started in June 2014. In this initial phase, JE surveillance was conducted in sentinel hospitals. As Bali has a long story on JE activities in previous studies, sentinel sites are also more prioritized in Bali. Each district general hospital (9 districts) and one province referral hospital are assigned to be sentinel sites. Beside Bali, three other provinces (North Sulawesi, West Kalimantan and East Nusatenggara) were also involved in this sentinel surveillance. Each province is represented only by one provincial hospital. Since then, more and more sentinel sites are added, that currently there are 29 hospital sentinel sites for JE, 23 of which are in Bali.

- **Supporting 50% of vaccine and logistics cost for a JE campaign** that will be given to target population aged 9 months to 14 years in all 9 districts of Bali Province in 2017. This campagin will be followed by GoI funded introduction of JE vaccine into routine program in Bali province. Indonesia ITAGI has also reviewed the disease data and recomended for JE Vaccine intorduction in Bali province

Details of JE Vaccine and reason for the choice of presentation

- With a relatively representative data in Bali, and in line with the recommendation of Indonesian Technical Advisory Group on Indonesia (ITAGI) MOH, decide to introduce JE vaccination in high risk province of Bali, preceded by a campaign. The Government of Indonesia is requesting GAVI support to procure 50% of JE vaccine and logistics for a one time catch up JE campaign and vaccine introduction grant (VIG). Both requests are to support the JE campaign and JE vaccine introduction, planned in 2017. Safe and effective WHO PQ JE vaccines are available to prevent disease. Indonesia requests for Chendu JE vaccine in 5 -dose vial (SA-14-14-2) presentation. The target age group for JE campaign will be 9 months to 14 years, with an estimated target population of 914,802. . MOH is also coordinating with PATH for possible support towards JE campaign (to suppliment GAVI support) and WHO for technical assitance in supporting prepardness and implementation activites.

1. **Total cost request for JE vaccine USD** 242.715 **(**50% of total campaign doses for a target population aged 9 months through 14 years)
   VIG for JE; USD 100,000
2. **Duration of support : 2016-2017**

- ***Measles Rubella CATCH UP Campaign*** MOH has taken a stretegic and important decesion to introduce Rubella vaccine in the National EPI program . As part of Rubella introrduction is propsed to conduct a MR catch up campaign targeting 69,877,300 million children 9 month to 15 years of age with preparation starting in last quarter of 2016 and implementation will be conducted in phased manner 2017 to 2018. It will be continued with routine MR vaccination as first dose of measles vaccine at 9 month of age and second dose at 18 month one month after after MR catch up campaign.

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- **The total amount of funds requested :**
- **Vaccine and logistic : USD 30.229.275 to support (**50% of total campaign doses for a target population of males and females aged 9 months to 14 years
- **Vaccine Intorduction Grant : USD 3,920,000 : (** $0.80 per child in the birth cohort to facilitate activities in the first year of MR introduction into routine immunisation.)
- **Duration of support 2016 to 2017**

Details of MR Vaccine and reason for the choice of presentation:

Indonesia requests for MR vaccine in 10 dose/vial, lyophilized presentation using local product by PT.Bio Farma. The MR catch up campaign will be implemented through outreach ("Posyandu"), Preschool, Elementary & Primary School, Health Centre, Hospital and clinic with minimal target is hundred children/ Booth. So, with10 doses/vial is effective presentation for this activity and it can be decreased wastage rate.

Projected month and year of introduction of MR vaccine (including for campaign and routine)

It has been decided to conduct MR catch up campaign and introduce MR vaccine in 3 phases commencing from 2017 to 2018 in following manner.

- Phase I in August 2017, at Java Island (West Java, Central Java, East Java, DKI Jakarta, Banten, Yogyakarta) as 53 % of the population. This phase will use all vaccine from GAVI contribution and some from GOI contribution
- Phase II in February 2018, at Sumatera Island (Nangroe Aceh Darussalam , North Sumatera, South Sumatera, West Sumatera, Bangka Belitung, Jambi, Lampung , Riau, Riau Island, Bengkulu) as 24% of population (**all Vaccine from Govt contribution**)
- Phase III in August 2018, at South Sulawesi, Central Sulawesi, West Sulawesi, North Sulawesi, South East Sulawesi, Gorontalo, West Kalimantan, North Kalimantan, South Kalimantan, Central Kalimantan , East Kalimantan, Bali, NTB,NTT, Maluku, North Maluku, Papua, and West Papua) as 23% of the population, All vaccines from GOI contribution

Baseline data:

As per administration report to JRF (2014) DPT3-92% and MCV1-91% with country estimate is 81%, The Riskesdas (Basic Health Survey) in 2013 shows that DPT3 coverage was 73% and measles 81%. The coverage of MCV1 in 2014, at national level is 91% and coverage of measles for school children grade 1 is 93, 4%. However, MCV1 coverage at the sub-national data revealed significant variation between provinces and districts: 258 (50,7%) districts out of 509 districts with coverage >90% and 101(18.4%) with coverage 80-89% (20%) and 142 (20%) district with coverage <80 of MCV1.

Indonesia has a strong experaince of conducting large scale vaccination campagins. A totol of 13 SIA's implemented in Indonesia since 2000 to 2011 with average coverage is 95%

Birth cohort is estimated from (HMIS): 2014- 671,701; 2015- 682,704;2016- 694,171; 2017- 706,194; 2018- 718,756;

Country preparedness:

As an important milestone to be achieved in Measles Elimination and Rubella/CRS control by 2020, Ministry of Health has issued a decree to establish national committee on Measles Elimination and Rubella/CRS control

This committee consists of five (5) working groups (sub-committees):

a. Working group on planning

b. Working group on implementation

c. Working group on logistics

d. Working group on communication

e. Working group on monitoring evaluation

Members of this committee were selected from various inter-ministerial/inter-sectoral government agencies: Ministry of Internal Affairs, Coordinating Ministry of People's Welfare; National Development Planning Agency (BAPPENAS), Audit Board of Republic Indonesia health institutions within the MoH (Finance, National Pharmacy (BINFAR), Environment Health, MCH, Nutrition, Referral for hospital services, Directorate, Central of Public Communication , National Institute of Health Research and Surveillance unit , health institutions from army, police and air-force, health providers from various religious organizations), Family Welfare Movement PT Bio Farma and National Regulatory Agency professional organizations (Indonesian Midwives Association Indonesian Medical Doctor Association Indonesian Pediatrician Association Indonesian Nurse Association, International NGO (Rotary, Lions Club); development agencies (WHO, UNICEF); others (Indonesian Technical Advisory Group on Immunization(ITAGI), Committee on AEFI (KIPI), Hospital Association (PERSI) , Indonesian Red Cross.

The tasks and responsibility of each working group are explained below:

a. Working group on Planning:

- Review the situation analysis of Measles/Rubella/CRS in the country including stakeholder analysis of various target groups, assess gaps on human health resources, health infrastructures at all levels.
- Develop budget needed for the Measles Rubella catch up campaign and introduction MR to routine and Surveillance MR integrated with VPD surveillance.
- Provide technical guidance and coordinate with planning subcommittee at the subnational level (provinces).

b. Working group on Logistics:

- Coordinate with P.T Bio Farma and BPOM regarding new vaccine readiness of MR (registration, licensure, production timelines and stock availability).
- Monitor the procurement process MR.
- Provide regular updates regarding logistics management system to the secretary of the working group.
- Provide technical guidance and coordinate with logistics subcommittee at the subnational level (provinces)

c. Working group on Implementation:

- Conduct advocacy and socialization activities on MR catch up campaign and introduction MR to the routine
- Conduct training on MR catch up campaign and MR introduction.
- Coordinate activities with inter-sectoral institutions and within Directorates in the Ministry of Health.
- Monitor the preparation of MR catch up campaign and MR introduction.
- Provide regular updates regarding implementation to the secretary of the working group
- Conduct technical guidance and coordination with implementation subcommittee at the subnational level (provinces).

d. Working group on Communication:

- Develop key messages and analyses target audiences, develop relevant materials used for Communication, Information and Education (IEC) for MR catch up Campaign and MR introduction.
- Coordinate with mass media to gain support for public awareness of MR catch up campaign and MR introduction
- Conduct documentation of all activities
- Provide technical guidance and coordinate with communication subcommittee at the subnational level (provinces).

d. Working group on Monitoring and Evaluation

- Ensure monitoring activities related to MR catch up campaign and introduction of MR to the routine.
- Compile data on MR catch up campaign and MR introduction
- Conduct quick assessment on the result of MR catch up campaign and MR introduction.
- Provide regular updates regarding monitoring and evaluation to the secretary of the working group

- Provide technical guidance and coordinate with monitoring and evaluation subcommittee at the subnational level (provinces).

Sub-national MR catch up campaign committees :

It is expected, that sub-national committees on MR catch up campaign will also be established in all 34 provinces and in all districts of the country for smooth implementation. The members of this sub-national/districts committee will vary among the provinces depend on their local situation and needs.

Lessonn learnt for previous NV introduction , We have identified all the critical planning activities should start -12 months before the month / date of introduction. The updated cMYP includes training material development, staff training; strengthen supply management, communication strategy and IEC material, AEFI & MR surveillance, vaccine impact evaluation.

MR Introduction into Routine

1. **Improvement of Service Delivery :**

Improvement service delivery will be done especially for hard to reached area and low performing through:

• Develop and reinforce the strategies to maintain the current unimmunized and drop-out rates at their lower level such as: mapping the causes of unimmunized and drop-out; conduct routine workshop each month in health centre to develop POA to address the unimmunized and drop-out. For example: change the immunization post schedule accordance with the community condition, use the SOS (Sustainable Outreach Services)

• Monitoring of infant vaccination status to track defaulters has been included into the integrated package of interventions at health centre level in hard to reach areas.

• Ministry of health has recently formed a special unit called DTPK to ensure that the implementation of health programs including immunization is take place in difficult to reach, underdeveloped, border and island areas. By integrating immunization into DTPK program, Indonesia may reach unreached areas through routine immunization and may increase the immunization coverage in these areas.

• Reinforce IEC activities for immunization through the intensification of routine immunization programme.

1. **Reinforce monitoring and evaluation**

Periodic evaluation of the program will help to identify problems related to the preparation of the new vaccine introduction into the current routine immunization program. All the current EPI management tools in use at different levels will be revised to incorporate specific information related to MR introduction and will be printed and be distributed to all levels.

PIE activity will be done 6 month after MR introduction to evaluate program and implementation at the field.

1. **Reinforcement of the staff capacity**

The MR introduction will be the opportunity for the health workers training with respect to specific aspects of this vaccine. Two key elements will be part of this component:

- Training of trainers and of the health workers

Training will help to improve the competency of staff at all levels and will 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. Training of trainers will be organized at central, province and district level and then the training of the health workers at the health facility level.

- Supportive supervision

Regular supportive supervision will be an excellent opportunity to reinforce the capacity of health workers in the field. The less performing health workers will be supervised by EPI focal point from the district health

office will supervise the health workers at health centre level. All the recommendations made during follow up activities will be implemented through the regular supportive supervision visits.

Following the first six months after the introduction of MR vaccine in each phase, supportive supervision will be regular from central level to the less performing health districts, every 2 months. Districts will supervise the health centres, especially the poorly performing health centres, once every two months. Supervision check-list will be updated with specific information related to MR vaccine introduction.

1. **Reinforcement of cold chain storage capacity**

Cold chain inventory assessment was conducted in 20 provinces in 2014 and continues in remaining 13 provinces in 2015. In 2014 and 2015, there are 655 refrigerators and 4955 vaccine carrier and temperature device procured based on cold chain inventory result.In addition, old cold chain equipment's in some districts already replaced. There is a need to fill the gap and accommodate the new vaccines with support from government , local goverments and partners.

1. **Reinforcement of communication and social mobilization**

Immunization services will develop closer links 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 linkage. Key messages which address parents' concerns for new vaccine introduction will be disseminate to the community through both health workers and volunteers.

Indonesian government is currently trying to implement equitable health services. For that purpose, MOH formed a special unit whose task was to ensure that the implementation of health programs including immunization can take place in difficult to reach areas, known by name Daerah Tertinggal, Perbatasan dan Kepulauan / DTPK (Underdeveloped, Border and Island areas). By integrated immunization into DTPK program, we will reach the unreached area routinely and hopefully this intervention will be increasing the immunization coverage.

1. **Reinforcement of epidemiological surveillance and of the AEFI**

- Measles Rubella disease surveillance and CRS surveillance

In 2008 Indonesia launched case based measles surveillance (CBMS) in Yogyakarta and Bali provinces and subsequently expanded to other provinces. By 2011 all provinces (33) switched to CBMS. Proportion of clinical samples from suspected measles cases test by laboratory as part of CBMS varied among provinces. In 2013 only 26% of cases in Indonesia were tested at the laboratory. The CBMS is supported by a network of four WHO accredited national measles laboratories in Surabaya, Jakarta, Bandung and Yogyakarta. An integral part of CBMS is outbreaks investigations – measles outbreaks should be investigated. Per WHO guideline, all suspected cases are tested for measles and if they results are negative, the sample will be tested for rubella.

To better understand the situation of the rubella and CRS epidemiology Indonesia conducted a series of pilot projects and studies. In 2013, two hospitals (Hasan Sadikin and Sardjito) conducted pilot studies on CRS. CBMS Data shows a high percentage of confirmed rubella cases above 15 years of age : 23-27% nationally, 39-40% in Yogyakarta (with better surveillance), the percentage even higher among women (48%)

- AEFI surveillance

Indonesia has has a very good AEFI Surveillance system in place to identify both serious and non-serious AEFI cases especially in the beginning of introduction. Training session on MR vaccine introduction will take into consideration the AEFI surveillance (identification, notification and case management). Current Web based AEFI reporting form available at health institutions and with the health professionals could be use to report AEFI following MR vaccine as well. Indonesia already developed module e-learning on basic vaccine safety training in Bahasa Indonesia and trained to all provinces. This module also can be used for health workers at the field and medical institution in Indonesia and neighbour countries (Malaysia, Singapore , Timor Leste and Brunei).

3 Request for a two year HPV demonstration project:

Indonesia MOH proposes to GAVI to fully fund a two year HPV demo project from 2017-2018 its proposed that the HPV Demonstration Programme will be conduct via a well estabilised school based immunization programme (BIAS) in two select districts of Yogjakarta province, Kulon Progo and Gunung Kidul District in

Yogyakarta Province. Both the districts have very high school enrollment rate and high budren of disease and a very strong political leadership in disctirct and province levels.

Cervical cancer epidemiology in Indonesia:

Cervical cancer is the 2nd most common cancer among women in Indonesia and as per the ICO HPV Information Centre 2015, there were 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. In Indonesia, 58 cases were diagnosed as cervical cancer and 26 cases of them were dead per day. The highest prevalent was at 3 provinces which are Yogyakarta, North Maluku, and Riau Islands with 1.5 / 1,000 population.

Curently, 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 Visual Acetic Acid Inspection (VIA) Methods and Pap's test for cervical cancer on this program.

Indonesia is committed to improve the health of women, and as such, the GoI seeks financial assistance for the HPV Demonstration Program which pilots a potentially comprehensive approach to the cervical cancer control.

HPV vaccine:

In Indonesia school eduction is Free and mandotary for all children and hence school enrolement very very high.

In Indonesia, both Quadrivalent and Bivalent HPV vaccines have already been licensed by NRA and have been used in private practices. There is a high demand for HPV vaccine and some provinces have expressed intrest to start HPV vaccination using local govt budgets.

Quadrivalent HPV vaccine is preffered 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). The target age group for HPV demonstration program is 5th grade girls in school in Kulon Progo and Gunung Kidul District in Yogyakarta Province, with the total amount of 7934 girls.The demonstration program will target the 5th grade primary school (girls aged 11 – 12 years old) in 2 districts in Kulon Progo and Gunung Kidul in Yogyakarta Province. The first dose will be given in September each year, soon after the commencement of the new school year, in order to complete the 2 doses within each academic year and align with existing school holidays and examination date. Eligible out of school girls (including those with a disability and aged 10 years) will be invited to come to nearby school on the day of the team's visit for HPV vaccination. 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 expected coverage is more than 95 %.

Request for Funding for HPV vaccines and injection supplies is expected to be provided by 100% by vaccine grant from GAVI. The operational will cost shared in composition GOI and technical support by WHO and other partners.

Total support requested for Two year HPV demo

1. **HVP vaccines ; USD** 100.552
2. **Operational cost :USD 338.924**
3. **Duration of suppport 2017-2018**

<u>Country prepardnessfor NVI</u>

Improvement of vaccine supply and management

Regular vaccine supply and correct vaccine stock management with other immunization supplies will be the key factors in the process of new vaccine introduction. This will need to continue with rational management of these supplies, assure their availability and limit their wastage. This will include the best vaccine forecasting taking into account the correct target population, vaccination coverage objective and potential vaccine wastages, good stock management and effort to improve the quality of vaccines.

Effective Vaccine management

Regarding EVM Policy in Indonesia, there is ministerial decree no. 42 in 2013 article 26 mentions about monitoring and evaluation on immunization program, one of the activities is EVM to identify strength and weakness in vaccine management, monitor and develop improvement plan. EVSM have been conducted at 35 sites in 2009, and 18 provinces in 2011- 2012. Some of the activities from EVM improvement plan 2012-2015 as the recommendation following the assessment such as SOP development, EVM tools, promote self-assessment, cold room mapping and inventory cold chain, new cold room provided in 2013. In cMYP 2015-2019 also included cold chain management and procurement of cold chain.

In 2014, CCE procurement is developed to implement CC inventory in 22 provinces but only 19 provinces have implemented CC inventory, Fridge tag-2 introduction and implemented in 2 provinces and 14 provinces has application for storage management system.

The main observations and recommendations of the 2015 EVM Assessment:

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.

Temperature Management with problems found: temperature monitoring devices are not available in all equipment; health workers do not know how to read temperature monitoring devices and do not know what to do when an alarm appears; storage equipment is cold and not always of PQS standard; Supervisory support is absent.

Stock Management with problems found: stock arrivals and issues are not recorded; a computerized system such as SMS is not used; diluents are not recorded; physical counts are not done; health workers do not know how to calculate minimum and maximum stock levels.

Management Information System & Supervision with problems found: lack of SOPs; lack of/or inadequate, training of supervisors; lack of funds for supervision and lack of human resources.

EVMA showed low training scores at all levels (except NVS), i.e. National level is 100%; Provincial level is 53% have received training; District level is 37% have received training and Health Centres level is 42% have received training.

Outcomes of 2015 EVM and follow up action to be input in EVM improvement plan 2016-2018.

Some strategic recommendations from EVMA 2015 as follow:

Strategic Goal 1 - Temperature Management

Temperature Monitoring Devices

Temperature Monitoring Studies

Temperature Mapping Studies

Temperature Alarm Management

Strategic Goal 2 - Stock Management

CCEI

Stock Registers

Supply intervals and distribution management

Strategic Goal 3 - MIS and Supervision

Technical Working Group

EVMA in Bahasa Indonesia

Guidance Documents

Strategic Goal 4 - Training

Strategic position of Biofarma

Role of guidance documents and SOPs

Learning by doing

Induction training for new workers

Transfer of Knowledge to Pharmacy

Refresher training for health workers

Training of supervisors and middle management

Training of senior managers

Sustainability

Stakeholders' participation in developing this proposal

Smooth introduction of the new vaccine goes through the reinforcement of the coordination, collaboration and partnership of all the involved partners. Technical Working Group and ITAGI activities through the quarterly meetings were done. Technical working group consists of Immunization sub directorate and technical partners (MCH, Health promotion, Nutrition, Surveillance etc.) meets on a monthly basis and monitor preparedness, implementation and evaluation activities for new vaccine introduction.

The Inter-Agency Coordinating Committee for Immunisation Agencies and partners (including development partners and Civil Society Organizations) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC/HSCC). The ICC/HSCC is responsible for coordinating and guiding the use of the GAVI ISS and NVS support. Members of ICC/HSCC are WHO Representative to Indonesia, UNICEF Representative to Indonesia, UNDP Representative to Indonesia, Resident Representative of the World Bank, Resident Representative of Asian Development Bank, Director of Population, Health & Nutrition USAID, Team Leader AusAID in Indonesia, Director of KFW Jakarta, Resident Representative JICA, Program Officer of Canadian/CIDA, President, Director of PT Biofarma Indonesia, Governor of Rotary Int. District 3400 Jakarta and Indonesian Red Cross.

The ICC/HSCC Indonesia is quite active and meets at least four times a year under the chairmanship of Hon. Minister of Health. All major decisions on financial sustainability and donor support for immunization including GAVI NVI, HSS, ISS and CSO are taken at the ICC/HSCC. All the three proposals for JE, MR and HPV demo) were discussed , reviewed & approved by the HSCC Meeting held on 13th January 2016 and endorsed.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Indonesia would like to expand the existing partnership with the Gavi for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests Gavi support for:

JE, 5 dose(s) per vial, LYOPHILISED; MR, 10 dose(s) per vial, LYOPHILISED
preventive campaigns

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 and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 2 and 3 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Untung Suseno	**Name**	Ayu Sukorini
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the Gavi Secretariat has queries on this document):

Full name	Position	Telephone	Email
Dr. Jane Soepardi	Director of Surveillance and Health Quarantine	+62811966169	janesoepardi@yahoo.com
Dr. Prima Yosephine	Chief, Sub Directorate of Immunization	+628128096106	primayosephine@yahoo.com
Dra. Engko Sosialine, Apt	Director of Public Medicine, Directorate of General of Pharmaceutical and Medical Device	+6281317098771	engko_sm@yahoo.com, engkosm@yahoo.com

4.1.2. National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation

Agencies and partners (including development partners and NGOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC, Health Sector Coordinating Committee (HSCC), or equivalent committee). The ICC, HSCC, or equivalent committee is responsible for coordinating and guiding the use of the Gavi NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	National Inter-Agency Coordinating Committee-ICC
Year of constitution of the current committee	2011
Organisational structure (e.g., sub-committee, stand-alone)	stand alone
Frequency of meetings	3 - 4 meetings anually

The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules is attached as DOCUMENT NUMBER : 4.

Major functions and responsibilities of the ICC/HSCC:

1. Provide technical support to NIP as necessary

2. Coordinate with international partners in the delivery of immunization services including resource mobilization.

3. Coordinate and monitor with otherhealth programs in relation to enhance effectiveness and quality service in immunizationand to assure program sustainability.

4. Invite any other international/nationalpartners involved in immunization program in Nepal for their input, feedbackand expertise.

5. Form sub-committees and workinggroups as necessary

6. Coordinate with GoN/NGOs and internationaldevelopment partners for mobilization of resources for immunization program

7. Assure effective and efficientuse of overall immunization and GAVI funds

8. Provide input during preparationof immunization annual work plan

9. Provide support and monitor ongoing polio eradication activities

Please describe how partners have provided support in preparation of the proposal:

1. Involvement in decision making, preparation and development of the proposal

2. The partners provided technical input during the preparation of the proposal, also supported in advocacy for relevent deaprtments. Setting up of small working groups for disease specific proposals. Coordnation with other departments, Medical association, MCH, NCD, reproductive health, School Health, MoE, Laboratroy, Health promotion, Bio farma, Director of logistics and procurments, ITAGI, AEFI committee,

Assited in pre- introdution assesments. like EVSM, Cold chain improvement plan, feild visits to make assesments specfically for JE in Bali. Consultation with HPV demostration slected districts to to verify their readiness, commitments, development of RI communication stategy which can be adapted for New vaccines. WHO supported in MR Cost effectiveness study through National Institute of Health Research and Development, Strengthening CRS Surveillance and JE surveillance for better understanding disease burden in country.

Partners like PATH, IVI will aslo be supporting in cost shasring for JE vaccine.

4.1.3. Signature Table for the Coordinating Committee for Immunisation

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **13/01/2016** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

Please refer to Annex C of the 'Gavi HSS and NVS General Guidelines' for more information on ICCs.

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Secretary General	Dr. Untung Suseno		
Secretary	Director of General of Prevention and Disease Control	Dr. M. Subuh		

Members	WHO	Dr. Vinod Bura		
	Unicef	Dr. Marisa Ricardo		
	Muslimat NU - CSO	Dr. Roosmani		
	YADJ - CSO	Dr. Sari Ningsih		
	Perdhaki - CSO	Meda		
	ITAGI	Dr. Toto Wisnu		
	ITAGI	Dr. Hingki Satari		
	Ministry of Finance	Royani		
	Bureau of Legal and Organization	Barlian		
	Planning and Budget Program and Information	Dr. Anas		
	Director of Heatlh Promotion	Dr. Dedy Kuswenda		

By submitting the proposal we confirm that the quorum has been met. **Yes**

The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER : 6.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country ? **Yes**

We the members of the NITAG met on the **28/12/2015** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation describing the decision-making process through which the recommendations were reached, attached as Document number 26.

4.2.1. The NITAG

Profile of the NITAG

Name of the NITAG	Indonesian Technical Advisory Group on Immunization (ITAGI)
Year of constitution of the current NITAG	2007
Organisational structure (e.g., sub-committee, stand-alone)	stand-alone
Frequency of meetings	at least four time annually

Function	Title / Organisation	Name
Chair	Professor of Pediatrics	Prof. Dr. dr. Sri Rezeki Hadinegoro
Secretary	Medical Epidemiologist	Dr. dr. Julitasari Sundoro
Members	Vice Chairman /Professor of Internal Medicine	Prof. Dr. dr. Samsuridjal Djauzi
	Professor of Internal Medicine	Prof. dr. H. Ali Sulaiman
	Professor of Microbiology	Prof. dr. Agus Syahrurrahcman
	Professor of Microbiology	Prof. dr. Amin Subandrio
	Professor of Pediatrics	Prof. Dr. dr. Ismoedijanto
	Professor of Public Health	Prof. Dr. dr. Sudarto Ronoatmodjo
	Professor of Pediatrics	Prof. Dr. dr. Kusnandi Rusmil
	Professor of Pediatrics	Prof. dr. Sri Suparyati Soenarto
	Professor of Pediatrics	Prof. dr. Cissy Kartasasmita
	Professor of Internal Medicine	Prof. Dr. dr. Zubairi Djoerban
	Pediatrician	Dr. dr. HIndra Irawan Satari
	Pediatrician	Dr. dr. Soedjatmiko

	Researcher	Dr. Soewarta Kosen
	Pediatrician	Dr. dr. Toto Wisnu Hendarto
	Internist	Dr. Kuntjoro Harimurti
	Public Health Practitioner	Dr. drg. Mardiati Nadjib

Major functions and responsibilities of the NITAG

The mandate of ITAGI is to provide advices to MOH through the Director General of the Communicable Disease Control (CDC) with ongoing timely medical, scientific, and public health advices relating to vaccines.

The ITAGI serves to advise the Ministry of Health:

- Conduct policy analysis and determine the most optimal national immunization Policy
- Advise the national government on the formulation of strategies for the control of vaccine preventable diseases through immunization
- Assist the national authorities in the monitoring of national immunization program so that impact can be measured and quantified
- Keep the national authorities updated on the latest scientific development in the area of vaccines and vaccine preventable diseases
- Advise, where appropriate, organizations, institutions or government agencies in the formulation of policies, plans and strategies for research and development in new vaccines and vaccine delivery technologies of the future
- Promote vaccine production to meet national and, where possible, even global needs for vaccines that are of high quality, in sufficient quantity and at affordable prices
- Promote collaboration between vaccine industries, national policies makers and national regulatory authorities to foster regional and national vaccine security
- Foster inter-departmental linkages for those disease that may already have a vaccine or a potential vaccine in the pipeline
- Promote partnership between government, civil society, industry and donors to promote immunization in a sustainable, scientifically and credible manner
- Be a link between national government and the regional and international technical bodies that work in immunization

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 8)**

5. Immunisation Programme Data

5.1 Background information

Please complete the table 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 (cMYP) (or equivalent plan) and attach a complete copy (with an Executive Summary) as DOCUMENT NUMBER 9. Please attach the cMYP costing tool as DOCUMENT NUMBER 10.
- Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER : 12
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- Please refer to the attached risk assessments in the case of yellow fever and meningitis A mass preventive campaigns.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	255,461,686	2015	MoH Decree No. HK.02.02/MENKES/117/2015
Birth cohort	4,893,435	2015	MoH Decree No. HK.02.02/MENKES/117/2015
Infant mortality rate (per 1000)	20	2015	MoH Decree No. HK.02.02/MENKES/117/2015
Surviving infants*[1]*	4,794,791	2015	MoH Decree No. HK.02.02/MENKES/117/2015
GNI per capita (US$)	3,420	2013	cMYP
Total Health Expenditure (THE) as a percentage of GDP	3	2013	http://www.who.int/countries/idn/en/
General government expenditure on health (GGHE) as % of General government expenditure	8	2016	Nota Keuangan beserta RAPBN 2016 (National Budget Plan 2016)

[3] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Routine New Vaccines Support

Preventive campaign support

If campaigns with JE, MR vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If they are included in the Introduction Plan or Plan of Action, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
Measles Campaign were conducted many in past 10 years Communication strategy for school based vaccination is different Needs, time and extra support for coordination with private schools cold chain & logistics capacity needs to be strengthen well in	Strong advocacy at local level update micro plans 2-3 months before SIA. Logistics , Vaccine management needs careful planning, trainings, AEFI guidelines to be revised, made simple Start early coordination with professional organizations, local govt, other departments

advance AEFI surveillance trainings are essential for Health workers. Detailed micro plan for Hard to reach areas migrant populations and migrants	Communication via social media, use of celebrities, local religious leaders to be strengthened

5.1.2 Health planning and budgeting

Please provide information on the planning and budgeting cycle in your country

National planning and budgeting cycle in Indonesia starts in January. It involves ministries, Director General of Budgeting, National Planning Development Body, the Parliament and the President. It consist of 19 steps, from the policy directed by the president, priority of development, budget ceiling, assumptions until review and approval by the parliament.

Please indicate the name and date of the relevant planning document for health

1. Comprehensive Multi-year Plan on Immunization (cMYP) (2015 - 2019)

2. EPI Annual Work Plan 2015-2016

3. Ministrial Decree on data, policies, standards

4. RISKESDAS 2013 survey data

5. Measles Rubella strategic Plan 2015-2020

Is the cMYP (or updated Multi-Year Plan) aligned with the proposal document (timing, content, etc.)

cMYP (2015-2019) is aligned with proposal document.

Please indicate the national planning budgeting cycle for health

Natioanal Health Program has planning and budget mechanism that assigned by Parliament and approval by President

Jan to Dec

Please indicate the national planning cycle for immunisation

Immunization program has planning and budget mechanism through review by the Bureau of Planning and Budget, MoH and then assigned by Parliament,

Jan to Dec

5.1.3 Gender and equity

Please describe any barriers to access, utilisation and delivery of immunisation services at district level (or equivalent) that are related to geographic, socio-economic and/or gender equity. Please describe actions taken to mitigate these barriers and highlight where these issues are addressed in the vaccine introduction plan(s).

There were no such barriers related to gender in immunisation program implementation in Indonesia. Based on IDHS 2007 and 2012 there is no difference DTP3 coverage between boy and girl (73% and 71%) , and no difference between male and female in measles cases (based on CBMS data, in 2015), number measles case in male is 247 and female is 237 case.

Bali is a province in Indonesia with Denpasar as the province's capital. Bali is also the name of the main island of the province. There are a few smaller islands around Bali such as Nusa Penida, Nusa Lembongan, Nusa Ceningan, and Serangan island.

The total population in Bali in 2015 is around 4 million with about equal numbers of males and females. Both genders have equal access to vaccination.

Geographically, Bali is relatively easy to access. All the 9 districts in the island can be accessed by road. An international airport serves people coming to and going from Bali by air and a number of sea ports serve those who travel by sea.

Bali used to be have agriculture as the main income of its people, but currently tourism has become the biggest revenue. In 2003, around 80% of Bali's economy depends on tourism. Therefore, controlling

communicable diseases is a priority because it affects the tourism.

In the coming JE campaign, as access, gender and socio economic will not be big problems, the important issue is advocacy, social mobilization, capacity building, evaluation and monitoring. Therefore all of those activities are put into the plan in all levels (national, province, districts and health centers).

Discuss how equity issues (geographic, socio-economic and/or gender) are being taken into account in the design of social mobilisation and other strategies to increase immunisation coverage. Highlight where these issues are addressed in the vaccine introduction plan(s).

Based on IDHS 2007 and 2012, there are found DTP3 coverage inequities in Indonesiasuch as geographic (95% in Jogja and 35% in Papua), mother's education (highest 86% and lowest is 26%), birth order (first child 76%, 6+ is 36%), wealth (Q5 85% and Q1 45%), by region (rural 67%, urban 77%).

With vaccine introduction, the iimprovement service delivery will be done especially for hard to reached area and low performing through:

- Develop and reinforce the microplans, strategies to maintain the current unimmunized and drop-out rates at their lower level such as:
- Mapping the causes of unimmunized and drop-out, focusing in know areas of missed children, urban areas, peri urban population and migramnt pockets.
- Conduct routine workshop each month in health centre to develop POA to address the unimmunized and drop-out. For example: change the immunization post schedule accordance with the community condition, use the SOS (Sustainable Outreach Services)
- Monitoring of infant vaccination status to track defaulters has been included into the integrated package of interventions at health centre level in hard to reach areas.
- Ministry of health has recently formed a special unit called DTPK to ensure that the implementation of health programs including immunization is take place in difficult to reach, underdeveloped, border and island areas. By integrating immunization into DTPK program, Indonesia may reach unreached areas through routine immunization and may increase the immunization coverage in these areas.
- Reinforce IEC activities for immunization through the intensification of routine immunization programme.
- Coordination with other departments to request help in reaching thier familes,like construction sites, planation areas,
- Intensified Monitoring durnig campagin in high risk areas to indentify any left our,missed pockets.
- extensive use of local INGO, NGO, PKK, local kaders, village leaders, volunters, Faith based organization to mobilise community. Using social Media for creating awrness,

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

YES,

In routine immunization, as well as campaigns, all reports on coverage is recorded by gender and analyised. so far the achievements are equal among males and females.

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

N/A

If available, please provide additional information and documents on subnational coverage data, e.g. comparing urban/rural districts or districts with highest/lowest coverage, etc.

2013 Riskesdas/Basic Health Survey results show that immunization coverage in urban setting is slightly higher than rural.

Characteristic

a. Rural

HB-0 : 85,9

BCG : 91,0

DPT-HB3 : 79,9

Polio 4 : 80,3

Measles : 84,1

bb. Urban

HB0 : 71,9

BCG : 83,9

DPT-HB3 :,71,1

Polio 4 : 73,4

Measles : 80,0

5.1.4 Data quality

Please attach a data quality assessment (DQA), report if one has been completed within the previous 48 months (DOCUMENT NUMBER: 27). If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 11, DOCUMENT NUMBER: 28).

If DQA not available, please briefly describe plans to establish mechanisms for data quality assessment.

Data Quality Self-Assessment (DQS) has been done in Indonesia at 166 districts and 208 supervisors at selected areas already trained about DQS, also 25 Mid-Level Managers trained for DQS in 2015. So they are responsible to conduct DQS at their areas responsible and do follow up action based on the result of DQS.

Please indicate what routine mechanisms to independently assess the quality of administrative data are in place, and if so what these mechanisms are and how they enable the country to track changes in data quality over time.

DQS conducted every year at different areas and Riskesdas (Basic Health Survey) conducted by NHIRD every 2 years including immunization coverage and data management

Riskesdas conducted is not only for coverage survey but also include serological survey

Please detail what household surveys have been conducted in recent years to independently assess immunisation coverage and equity, and describe any survey plans for the coming five year period.

- Baseline coverage survey done in 2015 at 31 districts in 10 provinces by University of Indonesia as independent organization
- Riskesdas 2013
- DHS 2012

Next plan (Riskesdas 2016, DHS 2017)

5.1.5 MCV Immunisation coverage

Please provide information concerning immunisation coverage related to measles-containing vaccines (MCV)

Table 5.1.5: MCV Immunisation coverage

Coverage	2011		2012		2013	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Measles 1*st* dose (%)	92.5	80	97.7	85	93	84
Measles 2*nd* dose (%)	105		91.9		89.1	

Coverage	2014		2015	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Measles 1*st* dose (%)	91		75.5	
Measles 2*nd* dose (%)	91.8		24.3	

Coverage	2011		2012		2013	
	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey
Supplementary Immunisation Activities (SIA) (%)	98					

Coverage	2014		2015	
	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey
Supplementary Immunisation Activities (SIA) (%)				

Note:

(1) National reported Administrative Coverage

(2) WHO/UNICEF estimates of national immunization coverage

Was the last Measles Supplementary Immunization Activities (SIA) administrative coverage or results of a survey of acceptable methodology **Administrative coverage**

5.2. Baseline and Annual Targets (NVS Routine Support)

No NVS Routine Support is requested

5.3. Targets for Preventive Campaign(s)

5.3.1 Targets (JE campaign)

Please specify cohort for Japanese Encephalitis vaccines (JEV):

JE Start **9 months**

JE End **14 years**

Cohort population = population 9 months - 14 years old

Gavi will only provide support to countries for Japanese Encephalitis catch-up campaign by providing 50% of the required doses of JE vaccine for a target population of males and females aged 9 months to 14 years (the exact range in the scope of 9 months to 14 years old will depend on JE in the country).

Table 5.3.1 Baseline NVS preventive campaign figures for JE

Number	Targets
	2017
Total target population	897,050
Wastage rate (%) for JE (campaign)	10
Maximum wastage rate value for JE (campaign)	10 %

5.3.2 Targets (MR campaign)

Please specify cohort for rubella-containing vaccines (RCV):

MR Start **9 months**

MR End **14 years**

Cohort population = population 9 months - 14 years old

Gavi will only provide support to countries for Rubella Containing Vaccine catch-up campaign by providing 50% of the required doses of MR vaccine for a target population of males and females aged 9 months to 14 years (the exact range in the scope of 9 months to 14 years old will depend on MR in the country).

Table 5.3.2 Baseline NVS preventive campaign figures for MR

Number	Targets
	2017
Total target population	36,776,100
Wastage rate (%) for MR (campaign)	20
Maximum wastage rate value for MR (campaign)	0 %

6. New and Under-Used Vaccines (NVS Routine)

No NVS Routine Support is requested

7. NVS Preventive Campaigns

7.1. Assessment of burden of relevant diseases related to campaigns (if available)

Disease	Title of the assessment	Date	Results
Japanese Encephalitis	A Hospital Based for JE Surveillance in Bali	2001 - 2003	JE incidence and case-fatality rates in Bali were comparable to those of other JE- endemic countries of Asia. Our findings contradict the common wisdom that JE is rare in tropical Asia. Hence, the geographical range of endemic JE is broader than previously described. The results of the study support the need to introduce JE vaccination into Bali.
	Cost effectiveness of JE immunization in Bali	2007 - 2008	JE vaccine is highly cost effective
	Japanese encephalitis (JE) results in significant mortality and disability in children in Asia. In I	2008	Japanese encephalitis (JE) results in significant mortality and disability in children in Asia. In Indonesia, despite recognition of JE virus transmission, reports of human disease have been few and from limited geographic areas. Hospital-based surveillance for acute encephalitis syndrome (AES) and JE in children 15 years of age and under was undertaken in 15 hospitals in six provinces from 2005 to 2006. High- and low-risk provinces in geographically dispersed areas were included. Health center-based surveillance also was undertaken in one province. Eighty-two JE cases were confirmedamong1,496AEScasesdetected.JEcaseswereconfirmedinallprovinces,buttheproportionvaried between 18% and 2% among provinces of different risk levels. Children younger than 10 years of age represented 95% of JE cases, and 47% of all cases either died or were disabled. The study shows JE is an endemic human disease across Indonesia. Immunization strategies are being considered
	Japanese encephalitis (JE) results in significant mortality and disability in children in Asia. In I	2008	Japanese encephalitis (JE) results in significant mortality and disability in children in Asia. In Indonesia, despite recognition of JE virus transmission, reports of human disease have been few and from limited geographic areas. Hospital-based surveillance for acute encephalitis syndrome (AES) and JE in children 15 years of age and under was undertaken in 15 hospitals in six provinces from 2005 to 2006. High- and low-risk provinces in geographically dispersed areas were included. Health center-based surveillance also was undertaken in one province. Eighty-two JE cases were confirmedamong1,496AEScasesdetected.JEcaseswereconfirmedinallprovinces,buttheproportionvaried between 18% and 2% among provinces of different risk levels. Children younger than 10 years of age represented 95% of JE cases, and 47% of all cases either died or were disabled. The study shows JE is an endemic human disease across Indonesia. Immunization strategies are being considered.
Rubella Serology Study	RISKESDAS	2007	Among women of all age group 13.45% women were negative for Rubella IgG --In 15-19 Years age group; 22% of women not protected against Rubella 20-24 year age group : 17.3% women negative for Rubella IgG

Please attach the Plan of Action for each campaign as Document No. 29,23 in Section 10.

7.1.1 Epidemiology and disease burden for JE

Please select at least one of the following information sources to justify JEV diseases burden results:

Epidemiological information on burden of disease:

☑ 1 - JE data from the JE/AES surveillance system including the definition of the geographical extent of high risk areas for JE

☐ 2 - Reports on outbreak or clustering of cases in the past three years

☐ 3 - In case of absence of data from JE/AES surveillance, data from rapid assessments and/or an argumentation on environmental and biological plausibility.

7.1.2 Epidemiology and disease burden for Measles-Rubella

Please select at least one of the following information sources to justify RCV diseases burden results:

Epidemiological information on burden of disease:

☑ 1 - Rubella data from the measles case-based surveillance system (including the age distribution of rubella cases)

☑ 2 - Rubella seroprevalence surveys

☑ 3 - Congenital Rubella Syndrome (CRS) burden information, e.g. retrospective search, modelled estimates for CRS burden, prospective surveillance

☐ 4 - Other

7.2.Request for JE, 5 dose(s) per vial, LYOPHILISED campaign support

7.2.1. Summary for JE campaign support

When is the country planning to conduct this campaign? **April 2017**

When is the country planning to introduce JE into routine immunisation? **June 2017**

Please give a summary of the cMYP and/or the JE, 5 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of JE, 5 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc) and describe the plans for social mobilisation and microplanning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only.

Prior to 2006, JE data in Indonesia were based on a number of studies conducted in a number of places. All of those studies revealed, that there are evidences that JE is endemic in Indonesia. However, since 2006 there have been no JE particular studies conducted, that there is a gap of data for almost 10 years.

An initiative to develop JE surveillance on a more routine purpose was conducted in June 2014. In this initial phase, JE surveillance was conducted in sentinel hospitals. As Bali has a long story on JE activities in previous studies, sentinel sites are also more prioritized in Bali. Each district general hospital (9 districts) and one province referral hospital are assigned to be sentinel sites. Beside Bali, three other provinces (North Sulawesi, West Kalimantan and East Nusatenggara) were also involved in this sentinel surveillance. Each province is represented only by one provincial hospital.

Since then, more and more sentinel sites are added, that currently there are 29 hospital sentinel sites for JE, 23 of which are in Bali.

With a relatively representative data in Bali, coupled with a relatively high population of pigs as amplifying factor and wide areas of rice fields as breeding places of mosquitoes and in line with the recommendation of ITAGI in its meeting on 7 October 2015, we decide to introduce JE vaccination in Bali, preceded by a campaign.

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain **equipment** and other **logistical** requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here). **All proposals** that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi. Please note that all Gavi-financed cold chain equipment needs to be WHO pre-qualified. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from Gavi.

An EVM assessment has been carried out in November 2015. The findings and recommendations of the assessment and improvement plan are attached with the proposal. With the existing cold chain capacity of 141.63 and 31.41liters available at the central level and Bali Province respectively, and that even in the peak of vaccine storage in September there is still some space available, there will be sufficient storage capacity for JE campaign and introduction of new vaccines of JE . All cold chain equipment in Indonesia are WHO PQ standard and there's cold chain maintain plan at province and district level.

Bali province will procure addtional cold chain equipment using local government budget

Please describe any plans for expanding measles surveillance to include rubella and plans for the introduction of Congenital Rubella Syndrome (CRS) surveillance.

JE campaign will be excelent opprotunity for the following routine immunization activitiy to be undertaken in Bali. As before the campaign number of immunization spesific activities through coordination meeting, training, logistic support enhance supervisi and monitoring and IEC will be undertaken and these activity will help not only to conduct JE campaign but also strengthen immunization routine services,

- Advocacy to pilitical leadership for ownership and sustainability of routine immunization
- Strengthening planning capacity at province level
- Strengthening microplanning routine immunization
- Strengthening helath worker technical knowledge and skill
- Strengthening vaccine and logistic management
- AEFI Surveiilance strenghtening
- Increasing public awarness on benefit of routine immunization including JE
- Enhancing JE/AES in Bali to demonstate the impact of JE vaccination by reduction JE cases

during the campaign RCA will be conducted to monitor the coverage and any area low coverage imediate corective action will taken

Indonesia under take periodic coverage survey for EPI and other health indicator such as Basic Health Survey (Riskesdas), IDHS.

EPI will try to incooperate JE spesific quesiotion in the next national survey - Basic Health Survey (Riskesdas).

Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NUMBER : 18).

7.2.2. Grant Support for Operational Costs of the JE Campaign

For this exceptional opportunity the operational cost for the JE campaign will not be supported by Gavi.

7.2.3 Evidence of introduction of JE in routine programme

Will the country initially benefit from donated vaccines in for the introduction of JE vaccines in the routine immunization? **Yes**

Please provide a statement with a commitment that the country can finance the introduction of Japanese Encephalitis Vaccine (JEV) into the routine programme through one of the following:(Please attach available documents AS DOCUMENT NUMBER 17 in Section 10. Attachments)

☐ 1 - A commercial contract for purchase of JE vaccine with or without shipping documents, invoice, etc.

☑ 2 - Integration of JEV into the cMYP with a corresponding increase in the budget line for vaccines in the health sector budget adequate to cover purchase of JEV (please highlight the budget line in the cMYP costing or other document showing the corresponding increase to cover the purchase of JEV)

☐ 3 - A letter from the Minister of Finance or Budget ensuring additional funding for JEV purchase. In this case, the country must show additional evidence that the country will include JE vaccination in the routine after the campaign.

☐ 4 - An MOU between government and donor(s) (or other written document that proves donor commitment) for at least one year for purchase of JE for use in the routine programme

☐ 5 - Other

7.2.4 JE surveillance indicators

Please provide information on the following indicators of the quality of JE surveillance for at least two years prior to application (if available):

Surveillance indicator	2014	2015
Reporting rate at national level *1)*	0.025	0.12
	100,000	100,000
Laboratory confirmation rate (%) *2)*	12.5	12.3

Note:

- 1) Reporting rate at national level: (number of reported AES cases per 100,000 population)
- 2) Laboratory confirmation rate: (% of tested AES cases that were JE igM-positive)

7.2.5 JE Vaccine introduction Grant

As part of the catalytic support offered to introduce Japanese Encephalitis into the routine programme, Gavi may provide the country with a Vaccine Introduction Grant.

Has a JE vaccine already been introduced nationally on a routine basis? **No**

Calculation of Vaccine Introduction Grant for the JE, 5 dose(s) per vial, LYOPHILISED

Please indicate in the tables below how the one-time Introduction Grant***[1]*** will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP). Gavi's support may not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the funds needed.

Year of New Vaccine Introduction	Birth cohort (from Table 5.1)	Gavi contribution per target person in US$	Total in US$
2017	4,893,435	0.80	3,914,748

[1] The Grant will be based on a maximum award of $0.80 per person in the birth cohort with a minimum starting grant award of $100,000

Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

The Government of Indonesia is requesting vaccine introduction grant (VIG) of US$ 0.80 per child in the birth cohort or a lumpsum of $100,000. Because the birth cohort in Bali is 64,551 (or tota amount $ 100,000). We

chose the higher option the VIG will be use prepareness planning and introduction of JE vaccine in routine immunization planned in June 2017.

The introduction cost will also funded by MoH, local government and technical support from WHO.

Advocacy meetings will be held at central, provincial, district and health center levels, involving members of parliament, professional organizations, public-private organizations and media people highlighting the need for the campaign. Different types of professional organization meetings will be used as an opportunity to dissemination messages. This will create awareness at all level and increase demand for all vaccines. Capacity building, coordination meetings, monitoring and evaluation will be conducted at all levels. IEC materials that include leaflets, brochures and others will be developed targeting local communities, religious leaders, political leaders and parents with purpose to create and increase demand for vaccine. The mass media such as television and radio will be used to disseminate the messages.

7.3.Request for MR, 10 dose(s) per vial, LYOPHILISED campaign support

7.3.1. Summary for MR campaign support

When is the country planning to conduct the MR catchup campaign? **August 2017**

When is the country planning to introduce MR into routine immunisation? **October 2017**

Please note that, due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address this issue.

Please give a summary of the cMYP and/or the MR, 10 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of MR, 10 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc) and describe the plans for social mobilisation and microplanning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only.

The country is planning to conduct the MR catchup campaign in 3 phases starting first phase in **July 2017, February & August 2018**

the country planning to introduce two dises of MR into routine immunizationin starting from September **2017, April & October 2018 , with in one month of complection of MR catch up after each phase. Both doses of exisiting Measles vaccine at 9 and 18 months will be repleced by MR vaccine, which will be procured by GoI funding. All vaccine procured from GAVI contribtion will be used in first phase of SIA ie in 2017.**

The MR catch up campaign will be implemented at outreach (“Posyandu), Health centers, Preschool, Elementary and primary school, Hospitals, Clinic including private services/ clinics with meticulous planning and coordiation with an aim to reach over 95% coverage nationally and in all districts of country.

Refer to Introducing Rubella Vaccine Plan Proposal (attachment no 15)

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain **equipment** and other **logistical** requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here). **All proposals** that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi. Please note that all Gavi-financed cold chain equipment needs to be WHO pre-qualified. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from Gavi.

Storage Capacity and Accommodation of MR Vaccine

A cold chain inventory assessment was conducted in 2008 and yearly provinces and districts update their respective cold chain inventories based on the 2008 data as baseline. Based on these data cold room capacity at the central and provincial level is considered sufficient. Total volume of vaccine storage capacity is 562 M3 at provincial level, while the routine vaccine storage capacity required for Province level is 133 M3 for 3 months storage

Accordingly existing cold chain capacity is well enough for the MR introduction and MR vaccine introduction will not demand in increased cold chain capacity since MR vaccine replace of measles vaccine.

MOH is in the process of updating cold chain inventory assessment again in 2014, completered in in 20 provinces and continued in 14 provinces in 2015. Based on the result of this assessment, there are 172 refrigerators and replacement spare parts procured in 2014 and 483 in 2015 for the provinces to strengthen district level cold storage capacity.Govt funds will be made available to strengthen CCL.

Please describe how the campaign activities will contribute to strengthening routine immunisation services. Please refer to specific activities to be undertaken during planning and implementation, to evaluate the

implementation of the routine strengthening activities completed during the campaign, and to assess, via an independent survey, the quality and coverage achieved through the campaign.

MR catch up campaign activities with strengthen the EPI health system., include preparations of new updated microplans at all levels, cold chain & logisticsplans, Supervsion and M&E plans, social mobilization, capacity building, develop IEC material to increase public awareness about immunisation will contribute to strengthening routine immunisation. Immunization services will develop closer links 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 linkage. Key messages which address parents' concerns for new vaccine introduction will be disseminate to the community through both health workers and volunteers.IEC materials in local languages, dielects will also be cncouraged

Indonesian government is currently trying to implement equitable health services. For that purpose, MOH formed a special unit whose task was to ensure that the implementation of health programs including immunization can take place in difficult to reach areas, known by name Daerah Tertinggal, Perbatasan dan Kepulauan / DTPK (Underdeveloped, Border and Island areas). By integrated immunization into DTPK program, we will reach the unreached area routinely and hopefully this intervention will be increasing the immunization coverage.

Please describe any plans for expanding measles surveillance to include rubella and plans for the introduction of Congenital Rubella Syndrome (CRS) surveillance.

•Regional & National target of rubella/CRS control by 2020

CRS surveillance guidelines finilizes, trainings conducted, 4 accrediated labs in place to support IgG and IgM testing as per WHO protocols

•CRS surveillance established in Indonesia to determine the scope of the problem, To detect and isolate affected infants rapidly, and to mitigate the consequences of the disease for infants and their families through early provision of appropriate medical care & Provide a baseline for documentation and verification of rubella control

In 2013, pilot CRS surveillance was established in 2 hospitals in Yogyakarta, Indonesia. In the first hospital, prospective CRS surveillance was conducted from September 1 to November 19th 2013. During this period, 151 new born infants underwent screening for hearing impairment, of whom 9 infants had abnormal hearing test results and 1 infant tested positive for rubella IgM.

supporeted by WHO , Indonesia is conducting the CRS surveillance at 13 sentinel hospitals started at the end of 2014. Till Nov 2015, 276 suspected CRS cases have been reported among children under 1 year of age. Eoordination with epidemiological activities, to ensure linkage of laboratory and epidemiologic data is ongoing.

Retrospective and prospective survey also conducted at those 13 sentinel hospitals to all children who born in 2011 – 2013.Data for retro study is bieng analyised

Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NUMBER : 18).

7.3.2. Grant Support for Operational Costs of the MR Campaign

For this exceptional opportunity the operational cost for the MR campaign will not be supported by Gavi.

7.3.3 Evidence of introduction of MR in routine programme

Please provide evidence that the country can finance the introduction of Rubella-Containing-Vaccine (RCV) into the routine programme through one of the following:(Please attach available documents AS DOCUMENT NUMBER 17 in Section 10. Attachments)

☐ 1 - A commercial contract for purchase of MR/MMR vaccine with or without shipping documents, invoice, etc.

☑ 2 - Integration of RCV into the cMYP with a corresponding increase in the budget line for vaccines in the health sector budget adequate to cover purchase of RCV (please highlight the budget line in the cMYP costing or other document showing the corresponding increase to cover the purchase of RCV).

☐ 3 - An MOU between government and donor(s) (or other written document) committing the donor(s) to support for at least one year, the purchase of RCV for use in the routine programme **OR** a letter from the Minister of Finance or Budget ensuring additional funding for RCV purchase. In this case, the country must show additional evidence that the country will include MR vaccination in the routine immediately after the campaign.

7.3.4 Introduction planning for RCV

Countries should describe their plan for introduction including surveillance activities:

Does Indonesia's cMYP include a plan for the introduction of RCV into the national programme? **Yes**

Please attach the Introduction Plan for the introduction of RCV into the national programme as **Document number 13** in Section 10 and also attach the Plan of Action for the campaign as **Document number 29** in Section 10. Please refer to the Gavi application guidelines for required components in the introduction plan and plan of action.

Refer to attachement 13 and Plan of Activities and Budget for MR Introduction Indonesia (29). MOH has fully commited to sefl finance MR vaccine for all routnie doses and complement the GAVI funded support for SIA vaccines.

7.3.5 Rubella Containing Vaccine introduction Grant

As part of the catalytic support offered to introduce Rubella Containing Vaccine into the routine programme, Gavi may provide the country with a Vaccine Introduction Grant.

Has a Rubella Containing vaccine already been introduced nationally on a routine basis? **No**

Calculation of Vaccine Introduction Grant for the MR, 10 dose(s) per vial, LYOPHILISED

Please indicate in the tables below how the one-time Introduction Grant***[1]*** will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP). Gavi's support may not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the funds needed.

Year of New Vaccine Introduction	Birth cohort (from Table 5.1)	Gavi contribution per target person in US$	Total in US$
2017	4,893,435	0.80	3,914,748

[1] The Grant will be based on a maximum award of $0.80 per person in the birth cohort with a minimum starting grant award of $100,000

Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

The GAVI Vaccine Introduction Grant will be use for strengthening, prepaprdness, coordination, management for switch of existing two doses of M to MR. Also for evalauation of MR introduction and PIE, Addtional funds from MOH will also be provided to ensure MR intorduction activites are fully supported. WHO Technical assitance will be ongoing for these activites.

8. Procurement and Management

8.1 Procurement and Management of New and Under-Used Vaccines Routine

No NVS Routine Support is requested

8.2 Procurement and Management for NVS Preventive Campaign(s)

8.2.1 Procurement and Management for JE, 5 dose(s) per vial, LYOPHILISED campaign

a) Please show how the support will operate and be managed including procurement of vaccines (Gavi expects that countries will procure vaccine and injection supplies through UNICEF):

The vaccine for the SIA will be procured through Biofarma supply division with a shipment schedule to be coordinated through its usual national supply mechanism to ensure timely arrival as well and appropriate storage capacity

Distribution of the vaccine and injection supplies within the province will follow the existing distribution system operated by the immunization focal persons in province and district level. The district will distribute the vaccine further to health centers, which will implement the campaign according to the microplanning they develop

b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred.

c) Please indicate if the campaign is going to be phased, and if so, how this will be done.

The campaign in 9 districts will be conducted in 2 phases according to the age groups (9 months to 6 years, and 7 – 15 years)

d) Please outline how coverage of the campaign will be monitored, reported and evaluated (refer to the cMYP and/or the JE, 5 dose(s) per vial, LYOPHILISED campaign introduction plan)

Monitoring activities will conduct from central to provinces, districts and Health centre before, during and aftre the campaign.

The campaign's coverage will reported daily from Health Centre to district level, dstrict to province level and province to cetral.

After campaign finish evaluation meeting will conduct in every level.

8.2.2 Procurement and Management for MR, 10 dose(s) per vial, LYOPHILISED campaign

a) Please show how the support will operate and be managed including procurement of vaccines (Gavi expects that countries will procure vaccine and injection supplies through UNICEF):

National store directly sends the vaccines and devices to the provinces through the provincial stores via aircraft and land routes whose cost are built in already in the annual contracting by MOH. It is to be noted that around 20% of the delivery points in the country account for 80% of infant population. The vaccines are generally transported in the special vaccine cold boxes supplied by Biofarma

b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred.

The fund will be transferred to EPI and EPI will transfer to Pharmacy unit to procure the vaccine from Biofarma.

c) Please indicate if the campaign is going to be phased, and if so, how this will be done.

N/A

d) Please outline how coverage of the campaign will be monitored, reported and evaluated (refer to the cMYP and/or the MR, 10 dose(s) per vial, LYOPHILISED campaign introduction plan)

Monitoring activities will conduct from central to provinces, districts and Health centre before, during and after the campaign.

The campaign's coverage will reported daily from Health Centre to district level, dstrict to province level and province to cetral.

After campaign finish evaluation meeting will conduct in every level.

8.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

Yes. for each vaccine used for national program, a licensure is needed. In general, Indonesia will use vaccines that are locally produced by the local vaccine producer (Biofarma). In case the vaccines is still in the production line in the next few years and vaccine should be introduced immediately, a joint procurement system is used with Biofarma as the focal point. In the process of licensure, if vaccines are needed urgently, an expedited procedure (fast track) will be used. Only NRA approved/ Licenced vaccines will be used.

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

JE, Cheng Du , 5 dose/vial presentation - in process NRA registration

MR Vaccine in a 10 dose/vial presentation - in process NRA registration

HPV Quadrivalent type 6,11,16,18 in a 1 dose/vial - registered

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

The vaccine for the SIA will be procured through Biofarma supply division with a shipment schedule to be coordinated through its usual national supply mechanism to ensure timely arrival as well and appropriate storage capacity .

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant.

NRA Indonesia has WHO certified and conduct regulary audit by WHO,

Point of Contact Ega Febriana

Phone Number : +6287883321966

email : eg1402@yahoo.com

8.4 Vaccine Management (EVSM/EVM/VMA)

It is mandatory for countries to conduct an Effective Vaccine Management (EVM) assessment prior to an application for the introduction of a new vaccine. This EVM should have been conducted within the preceding **5 years**.

When was the EVM conducted? **October 2015**

Please attach the most recent EVM assessment report (DOCUMENT NUMBER : 20,19,21), the corresponding EVM improvement plan (DOCUMENT NUMBER : 19) and progress on the EVM improvement plan (DOCUMENT NUMBER : 21). The improvement plan should include a timeline, budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor progress of implementation.

If any of the above mandatory documents (EVM Assessment Report, EVM Improvement Plan, Progress on the EVM Improvement Plan) are not available, please provide justification and reference to additional documents such as PIE and External EPI Reviews.

When is the next Effective Vaccine Management (EVM) Assessment planned? **January 2018**

EVM assessment was conducted in October 2015 in 17 provinces.

The main observations and recommendations of the 2015 EVM Assessment:

2015 EVMA Major Challenges: 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.

Temperature Management with problems found: temperature monitoring devices are not available in all equipment; health workers do not know how to read temperature monitoring devices and do not know what to do when an alarm appears; storage equipment is cold and not always of PQS standard; Supervisory support is absent. Possible solution : provide adequate funding for procurement of temperature monitoring devices, train health workers to read the devices, monitor and react to alarms, provide supportive supervision for the health worker and regular review of temperature records, provide adequate quality cold chain equipment and include in the CCE Inventory, conduct temperature mapping studies, and conduct temperature monitoring studies.

Stock Management with problems found: stock arrivals and issues are not recorded; a computerized system such as SMS is not used; diluents are not recorded; physical counts are not done; health workers do not know how to calculate minimum and maximum stock levels. Possible solutions: use computerized system, conduct regular physical counts, increase supervision and supervisory budget and provide on the-job training in stock management.

Management Information System & Supervision with problems found: lack of SOPs ; lack of/or inadequate, training of supervisors; lack of funds for supervision ; lack of human resources. Possible solutions: provide adequate funding for supervision, record supervisory visits and use standardized check-lists, institute feed-back procedures of supervisory visits to health workers, implement good work plans with mechanisms to transfer knowledge between health workers and trained supervisors

EVMA showed low training scores at all levels (except NVS), i.e. National level is 100%; Provincial level is 53% have received training; District level is 37% have received training and Puskesmas level is 42% have received training.

Outcomes of 2015 EVM and follow up action to be input in EVM improvement plan 2016-2018, which is being impemented as part of annual EPI paln in coordination with WHO/UNICEF and GAVI support.

8.5 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare

waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

MOH has a very stringent Medical waste managment policy, and EPI too has a immunization waste management policy & Standard Operational Procedures of immunization including safe injection. .

The waste generated through routine and campaign immunization program are mainly disposed through burn and bury method. All Used syringes are collected in safety boxes and used vials in seperate bags. The used vials are crushed& buried. The safety boxes are incinerated where incinerators are available. Safety boxes from municipalities are collected at districts and incinerated where as in rural area safety boxes are burned and buried at the end of each vaccination day. He number of incriniatros are increasing rapidly specfically in urban areas and hospitals, there are being utilised by EPI program to dispose the EPI waste managemnt.. In campagin tranings guidelines and NV Intorduction guidelines proper waste managemnt and injection safety will be reinforced.

Injection safety has been included in the new immunization guidelines and the Health Minister's Decree about Immunization Program Management, which is still in process to be approved by the Minister, and have also developed the Standard Operational Procedures of immunization including safe injection. Most provinces and districts had trained their staff also. However, the issue of high turn-over of health workers still exist and continues training and supervision is needed. The MoH has focussed on continuous training and sources of funding such the GAVI HSS funding have been utilized in training and capacity building activities, but it is limited in 5 selected provinces (Banten, West Java, South Sulawesi, Papua dan West Papua). However, the MoH has provided training to 184 selected low performing districts supervisors and the 33 provinces supervisors. This training includes micro planning, vaccine and cold chain management, Local Area Monitoring, RED, supportive supervision and waste management and injection safety.

The GoI conducted monitoring activities to ensure that the safe injection practice was well implemented. The Health Human Resources Development Body from the MoH has included immunization lecture in the curriculum of health school institutions.

It is expected that the introduction of Rubella /JE /HPV will not have major impact the on waste management, a system already in place and the waste management and injection safety will be incorporated appropriately in the technical guidelines. Waste managment will also be monitored in supervisory visits and policy reinforced.

9. Additional Comments and Recommendations from the National Coordinating Body (ICC/HSCC)

Comments and Recommendations from the National Coordinating Body (ICC/HSCC)

Please kindly find the minutes of meeting document number 5 (the minutes of meeting January 13, 2016),

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	JE Approval MoH-MoF.pdf **File desc:** MoH and MoF Signatures of the Government and HSCC for Catch Up Campaign of JE proposal **Date/time :** 15/01/2016 10:06:05 **Size:** 7 MB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Approve MR from MoH-MoF.pdf **File desc:** MoH and MoF Signatures of the Government and HSCC for Catch Up Campaign of MR proposal **Date/time :** 15/01/2016 10:08:00 **Size:** 8 MB
4	Terms of Reference for the ICC	4.1.2	4. ToR for the ICC.docx **File desc:** ToR for the HSCC **Date/time :** 13/01/2016 08:46:04 **Size:** 13 KB
5	Minutes of ICC/HSCC meeting endorsing Proposal	4.1.3	Minutes of Meeting HSCC GAVI 13 Jan 2016.doc **File desc:** Minutes of Meeting HSCC GAVI 13 Jan 2016 for endorsed these proposal **Date/time :** 13/01/2016 08:42:05 **Size:** 56 KB
6	Signatures of ICC or HSCC or equivalent in Proposal	4.1.3	fwdscanapprovejemrhpv.zip **File desc:** Signature of HSCC Members **Date/time :** 13/01/2016 08:41:28 **Size:** 1 MB
7	Minutes of last three ICC/HSCC meetings	4.1.3	minutesoflast3icc.rar **File desc:** Minutes of Meeting HSCC in 2015 **Date/time :** 13/01/2016 08:47:17 **Size:** 49 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	10. Role and function of NITAG.doc **File desc:** Role and function of NITAD **Date/time :** 13/01/2016 08:48:36 **Size:** 262 KB
Planning, financing and vaccine management			
9	comprehensive Multi Year Plan - cMYP	5.1	cYMP.rar **File desc:** New cMYP 2015 - 2019 **Date/time :** 13/01/2016 09:42:46 **Size:** 1 MB

10	cMYP Costing tool for financial analysis	5.1	12. cMYO costing tool for financial analysis.docx **File desc:** cMYP Costing tool 2015 - 2019 **Date/time :** 13/01/2016 08:51:57 **Size:** 44 KB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.5	Guideline of JE Monev.pdf **File desc:** JE M&E **Date/time :** 15/01/2016 10:02:14 **Size:** 582 KB
13	Introduction Plan for the introduction of RCV / JE / Men A / YF into the national programme	7.x.4	JE action plan.doc **File desc:** JE Action Plan **Date/time :** 15/01/2016 08:39:01 **Size:** 1 MB
17	Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV	7.x.3	Introduction of MR.pdf **File desc:** Approved from HSCC meeting for MR Introduction **Date/time :** 15/01/2016 05:07:42 **Size:** 328 KB
18	Campaign target population documentation	7.x.1, 6.x.1	Data Sasaran Program 2016-2019.zip **File desc:** Target Population Data for Health Development 2016 - 2019 **Date/time :** 16/01/2016 11:42:51 **Size:** 68 MB
19	EVM report	8.3	Indonesia_EVM_report_16Nov2015_final.doc **File desc:** Indonesia EVM reported 2015 **Date/time :** 15/01/2016 01:25:51 **Size:** 7 MB
20	Improvement plan based on EVM	8.3	EVM Improvement Plan Indonesia 2015-2020 v219nov.docx **File desc:** Indonesia EVM Improvement Plan in Indonesia 2015 - 2020 **Date/time :** 15/01/2016 01:28:16 **Size:** 1 MB
21	EVM improvement plan progress report	8.3	EVM Improvement Plan Indonesia 2015-2020 v219nov.docx **File desc:** Indonesia EVM Improvement Plan in Indonesia 2015 - 2020 **Date/time :** 13/01/2016 08:59:33 **Size:** 1 MB
27	Data quality assessment (DQA) report	5.1.5	Results baseline coverage survey by independent organization.pdf **File desc:** Recent EPI coverage survey, **Date/time :** 15/01/2016 10:22:15 **Size:** 1 MB
29	Plan of Action for campaigns	7.1, 7.x.4	Plan MR.doc **File desc:** Plan of MR Campaign **Date/time :** 15/01/2016 10:23:58 **Size:** 491 KB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	Signature Approve for HPV.jpeg **File desc:** Signature of HPV Proposal, MoE no needed due to MoH has been working with MoE for Immunization at school **Date/time :** 16/01/2016 10:09:58 **Size:** 695 KB
12	Vaccine introduction plan	5.1	MR and HPV Introduction Plan.zip **File desc:** Chronogram/timeline for HPV Demonstration Program **Date/time :** 15/01/2016 10:16:06 **Size:** 438 KB
15	HPV roadmap or strategy	6.1.1	Update Chronogram NVS HPV Demo Application Form for 2016.xls **File desc:** HPV Summary of Evaluation of Methodology **Date/time :** 15/01/2016 10:17:01 **Size:** 64 KB
16	HPV summary of the evaluation methodology	5.1.6	HPV Summary of Evaluation of Methodology.doc **File desc:** Result of Baseline Coverage Survey Immunizatio 2015 by Independent Organization **Date/time :** 15/01/2016 10:17:57 **Size:** 27 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2, 6.x.2	VIG proposal.zip **File desc:** VIG for JE, MR and HPV proposal **Date/time :** 16/01/2016 10:15:47 **Size:** 161 KB
23	Risk assessment and consensus meeting report for MenA. If the DPT was used instead, please include this.	7.1	No file loaded
25	A description of partner participation in preparing the application	4.1.3	Description Partner participant.pdf **File desc:** Brief Description of Partner participant in preparing GAVI proposal **Date/time :** 15/01/2016 10:33:36 **Size:** 133 KB
26	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	fwdfwrekomendasijemrdankajianhpvfinal.rar **File desc:** ITAGI Recommendation and Review for HPV, JE and MR **Date/time :** 13/01/2016 09:06:08 **Size:** 1 MB
28	DQA improvement plan	5.1.5	No file loaded
30	Other		Indonesia-School-immunization.pdf **File desc:** Report on Indonesia School Program **Date/time :** 15/01/2016 12:57:33 **Size:** 361 KB

			Prevelence JE Surveilance in Bali.pdf **File desc:** Prevelence of Study JE **Date/time :** 15/01/2016 02:12:17 **Size:** 54 KB
			2006 BMC Medicine etiologic fraction of AES that is JE in Bali Word.doc **File desc:** JE Study in Bali **Date/time :** 15/01/2016 02:12:56 **Size:** 156 KB
			2008 AJTMH etiologic fraction of AES that is JE in six Indonesian sites.pdf **File desc:** JE Study **Date/time :** 15/01/2016 02:13:24 **Size:** 290 KB
			DATA SUMMARY OF JE IN INDONESIA.pdf **File desc:** Summary of JE activities **Date/time :** 15/01/2016 02:14:05 **Size:** 781 KB
			Isolated_JE in Bali.pdf **File desc:** Isolated JE Virus In Indonesia **Date/time :** 15/01/2016 02:16:10 **Size:** 839 KB
			MoM JE 07 oct.doc **File desc:** Minutes of Meeting ITAGI for JE (Oct 2015) **Date/time :** 15/01/2016 02:23:35 **Size:** 29 KB
			Notes for Proposal.doc **File desc:** **Date/time :** 16/01/2016 10:16:36 **Size:** 23 KB

11. Annexes

Annex 1 - NVS Routine Support

No NVS Routine Support is requested

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

Annex 3.1 - NVS Preventive campaign(s) (JE, 5 dose(s) per vial, LYOPHILISED)

Table Annex 3.1 C: Summary table for CAMPAIGN JE, 5 dose(s) per vial, LYOPHILISED

ID		Data from		2017
	Total target population	Table 5.2	#	897,050
	Number of doses per persons	Parameter	#	1
	Wastage Rate	Table 6.4.1	#	10
	Estimated vaccine wastage factor	Table 5.2	#	1.11
	Number of doses per vial	Parameter	#	5
	AD syringes required	Parameter	#	Yes
	Reconstitution syringes required	Parameter	#	Yes
	Safety boxes required	Parameter	#	Yes
gs	**Gavi support**	Parameter	%	50%
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.041
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.003
cs	**Safety box price per unit**	Table Annexes 4A	$	0.005
fv	**Freight cost as % of vaccines value**	Table Annexes 4B	%	7.21%
fd	**Freight cost as % of devices value**	Parameter	%	0

Table Annex 3.1 D: Estimated numbers for JE, 5 dose(s) per vial, LYOPHILISED, associated injection safety material and related country budget (page 1)

		Formula	2017		
			Total	Government	Gavi
A	Gavi support	*Gavi support (gs)*	50.00 %		
B	Total target population	*Table 5.3.1*	897,050	448,525	448,525
C	Number of doses per persons	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	897,050	448,525	448,525
E	Estimated vaccine wastage factor	*100 / (100 - Vaccine wastage rate)*	1.11		
F	Number of doses needed including wastage	*D x E*	995,726	497,863	497,863
G	Vaccines buffer stock	*0*	0	0	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	995,750	497,875	497,875
J	Number of doses per vial	*Vaccine parameter*	5		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	995,726	497,863	497,863
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	221,057	110,529	110,528
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	13,507	6,754	6,753
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	414,232	207,116	207,116
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	40,578	20,289	20,289
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	678	339	339
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	69	35	34
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	29,873	14,937	14,936
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	485,430	242,715	242,715

Note: Gavi vaccine support is limited to 50% of the required number of doses for the campaign, and a Vaccine Introduction Grant for the routine introduction.

Annex 3.2 - NVS Preventive campaign(s) (MR, 10 dose(s) per vial, LYOPHILISED)

Table Annex 3.2 C: Summary table for CAMPAIGN MR, 10 dose(s) per vial, LYOPHILISED

ID		Data from		2017
	Total target population	Table 5.2	#	36,776,100
	Number of doses per persons	Parameter	#	1
	Wastage Rate	Table 6.4.1	#	20
	Estimated vaccine wastage factor	Table 5.2	#	1.25
	Number of doses per vial	Parameter	#	10
	AD syringes required	Parameter	#	Yes
	Reconstitution syringes required	Parameter	#	Yes
	Safety boxes required	Parameter	#	Yes
gs	**Gavi support**	Parameter	%	50%
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.041
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.003
cs	**Safety box price per unit**	Table Annexes 4A	$	0.005
fv	**Freight cost as % of vaccines value**	Table Annexes 4B	%	2.48%
fd	**Freight cost as % of devices value**	Parameter	%	0

Table Annex 3.2 D: Estimated numbers for MR, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related country budget (page 1)

		Formula	2017		
			Total	Government	Gavi
A	Gavi support	*Gavi support (gs)*	50.00 %		
B	Total target population	*Table 5.3.1*	36,776,100	18,388,050	18,388,050
C	Number of doses per persons	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	36,776,100	18,388,050	18,388,050
E	Estimated vaccine wastage factor	*100 / (100 - Vaccine wastage rate)*	1.25		
F	Number of doses needed including wastage	*D x E*	45,970,125	22,985,063	22,985,062
G	Vaccines buffer stock	*0*	0	0	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	45,970,200	22,985,100	22,985,100
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	40,821,471	20,410,736	20,410,735
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	5,102,693	2,551,347	2,551,346
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	509,759	254,880	254,879
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	27,857,942	13,928,971	13,928,971
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,663,548	831,774	831,774
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	15,650	7,825	7,825
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	2,581	1,291	1,290
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	689,554	344,777	344,777
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	30,229,275	15,114,638	15,114,637

Note: Gavi vaccine support is limited to 50% of the required number of doses for the campaign, and a Vaccine Introduction Grant for the routine introduction.

Annex 4

Table Annex 4A: Commodities Cost

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2017
JE, 5 dose(s) per vial, LYOPHILISED	JE	7.21 %
MR, 10 dose(s) per vial, LYOPHILISED	MR	2.48 %

Table Annex 4D: Wastage rates and factors

The following table shows the wastage rates for routine and campaign vaccines, set for 2017.

Vaccine	dose(s) per vial	Maximum Vaccine wastage rate*		Benchmark Wastage Rate**
HPV bivalent, 2 dose(s) per vial, LIQUID	2	10 %	0 %	
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5 %	0 %	
JE, 5 dose(s) per vial, LYOPHILISED	5	10 %	10 %	
Measles second dose, 10 dose(s) per vial, LYOPHILISED	10	40 %	0 %	
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	10	10 %	0 %	
MR, 10 dose(s) per vial, LYOPHILISED	10	15 %	0 %	
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	10 %	0 %	
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	5 %	0 %	
Rotavirus, 2-dose schedule	1	5 %	0 %	
Rotavirus, 3-dose schedule	1	5 %	0 %	
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	40 %	0 %	
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	10 %	0 %	

Comments:

* Source - WHO indicative wastage rates

** Source - Country APRs and studies, approved by WHO, UNICEF, and the Gavi Secretariat

Note: HPV demonstration project wastage rates are the same as for the national introduction of the vaccine

Table Annex 4E: Vaccine maximum packed volumes

Kindly note that this table is for reference purposes only and includes Gavi- and non Gavi-supported vaccines.

Vaccine product	Designation	Vaccine formulation	Admin route	No. Of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
BCG	BCG	lyophilized	ID	1	20	1.2	0.7
Diphtheria-Tetanus	DT	liquid	IM	3	10	3	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	20	2.5	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	10	3	
DTP liquid + Hib freeze-dried	DTP+Hib	liquid+lyop.	IM	3	1	45	
DTP-HepB combined	DTP-HepB	liquid	IM	3	1	9.7	
DTP-HepB combined	DTP-HepB	liquid	IM	3	2	6	
DTP-HepB combined	DTP-HepB	liquid	IM	3	10	3	
DTP-HepB liquid + Hib freeze-dried	DTP-Hib	liquid	IM	3	10	2.5	
DTP-HepB liquid + Hib freeze-dried	DTP-HepB+Hib	liquid+lyop.	IM	3	1	22	

DTP-HepB-Hib liquid	DTP-HepB+Hib	liquid+lyop.	IM	3	2	11	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	10	4.4	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	2	13.1	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	1	19.2	
DTP-Hib combined liquid	DTP+Hib	liquid+lyop.	IM	3	10	12	
DTP-Hib combined liquid	DTP-Hib	liquid	IM	3	1	32.3	
Hepatitis B	HepB	liquid	IM	3	1	18	
Hepatitis B	HepB	liquid	IM	3	2	13	
Hepatitis B	HepB	liquid	IM	3	6	4.5	
Hepatitis B	HepB	liquid	IM	3	10	4	
Hepatitis B UniJect	HepB	liquid	IM	3	Uniject	12	
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	1	13	35
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	2	6	
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	10	2.5	3
Hib liquid	Hib_liq	liquid	IM	3	1	15	
Hib liquid	Hib_liq	liquid	IM	3	10	2.5	
Human Papilomavirus vaccine	HPV	liquid	IM	3	1	15	
Human Papilomavirus vaccine	HPV	liquid	IM	3	2	5.7	
Japanese Encephalitis	JE_lyo	lyophilized	SC	1	5	2.5	2.9
Measles	Measles	lyophilized	SC	1	1	26.1	20
Measles	Measles	lyophilized	SC	1	2	13.1	13.1
Measles	Measles	lyophilized	SC	1	5	5.2	7
Measles	Measles	lyophilized	SC	1	10	3.5	4
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	1	26.1	26.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	2	13.1	13.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	5	5.2	7
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	10	3	4
Measles-Rubella freeze dried	MR	lyophilized	SC	1	1	26.1	26.1
Measles-Rubella freeze dried	MR	lyophilized	SC	1	2	13.1	13.1
Measles-Rubella freeze dried	MR	lyophilized	SC	1	5	5.2	7
Measles-Rubella freeze dried	MR	lyophilized	SC	1	10	2.5	4
Meningitis A conjugate	Men_A	lyophilized	IM	1	10	2.6	4
Meningitis A/C	MV_A/C	lyophilized	SC	1	10	2.5	4
Meningitis A/C	MV_A/C	lyophilized	SC	1	50	1.5	3
Meningitis W135	MV_W135	lyophilized	SC	1	10	2.5	4
Meningococcal A/C/W/	MV_A/C/W	lyophilized	SC	1	50	1.5	3

Meningococcal A/C/W/Y	MV_A/C/W/Y	lyophilized	SC	1	10	2.5	4
Monovalent OPV-1	mOPV1	liquid	Oral		20	1.5	
Monovalent OPV-3	mOPV3	liquid	Oral		20	1.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	1	11.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	2	4.8	
Pneumo. conjugate vaccine 13-valent	PCV-13	liquid	IM	3	1	12	
Polio	OPV	liquid	Oral	4	10	2	
Polio	OPV	liquid	Oral	4	20	1	
Polio inactivated	IPV	liquid	IM	3	PFS	107.4	
Polio inactivated	IPV	liquid	IM	3	10	2.5	
Polio inactivated	IPV	liquid	IM	3	1	15.7	
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
Tetanus Toxoid	TT	liquid	IM	2	10	3	
Tetanus Toxoid	TT	liquid	IM	2	20	2.5	
Tetanus Toxoid UniJect	TT	liquid	IM	2	Unijject	12	
Tetanus-Diphtheria	Td	liquid	IM	2	10	3	
Yellow fever	YF	lyophilized	SC	1	5	6.5	7
Yellow fever	YF	lyophilized	SC	1	10	2.5	3
Yellow fever	YF	lyophilized	SC	1	20	1.5	2
Yellow fever	YF	lyophilized	SC	1	50	0.7	1

12. Banking Form

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

Name of Institution (Account Holder):	DIRECTORATE GENERAL OF PREVENTION AND DISEASE CONTROL, MINISTRY OF HEALTH REPUBLIC OF INDONESIA
Address:	JL, PERCETAKAN NEGARA NO. 29 JAKARTA PUSAT
City Country:	JAKARTA - INDONESIA
Telephone no.:	+62214257044 **Fax no.:** +62214257044
	Currency of the bank account: IDR
For credit to:	
Bank account's title:	RPL 140 DITJEN PPM DAN PL_GAVI
Bank account no.:	123-000413505-1
Bank's name:	MANDIRI

Is the bank account exclusively to be used by this program? True

By who is the account audited? THE FINANCE AND DEVELOPMENT SUPERVISORY AGENCY (BPKP)

Signature of Government's authorizing official

Name:		**Seal**
Title:		
Signature:		
Date:		

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**	
Bank Name:	MANDIRI		
Branch Name:	PERCETAKAN NEGARA		
Address:	JL. PERCETAKAN NEGARA NO.29		
City Country:	JAKARTA - INDONESIA		
Swift Code:	BMRIIDJA		
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account No is held by at this banking institution

The account is to be signed jointly by at least (number of signatories) of the following authorized signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorizing official
Signature:
Date:
Seal: