Internal Appraisal 2014

Indonesia

1. Brief Description of Process

A partners' mission to Indonesia in March 2014 worked with the Ministry of Health to ensure that HSS activities more effectively contribute to EPI targets, and checked on the status of the Pentavalent rollout which began in August 2013. Updates gathered during this mission formed the basis of the first version of this Internal Appraisal, which was drafted by the CRO and then circulated for input within the Secretariat and to partners.

The Appraisal concerns renewal of Pentavalent vaccine support for Year 3 (2015) of the 2013-16 Grant, an amount of US$ 13,843,500. Indonesia self-procures Pentavalent from its national manufacturer BioFarma. The Appraisal also contains an update on the current HSS grant. The final tranche of funding of US$ 9.4 million for this Grant was recommended for approval by the IRC in October 2013, and no additional action is requested from the Panel on this.

29 July 2014: Please note that the 2013 WUENIC estimates were issued after this Appraisal was completed, but prior to the High Level Review Panel, which was able to take the updated situation into account in its deliberations.

DTP3 coverage estimates increased significantly for 2011, 2012 and 2013, from 62%, 64% and 65% to 81%, 83% and 85% respectively. The Appraisal should be read with this in mind. Specifically, the comment in Section 2 below about the performance of Indonesia's immunization programme having stagnated over recent years is no longer accurate. Likewise, the comment in Section 6 below about a >20% discrepancy (84% versus 63%) between administrative and WHO/UNICEF DTP3 estimates is now outdated.

2. Achievements and Constraints

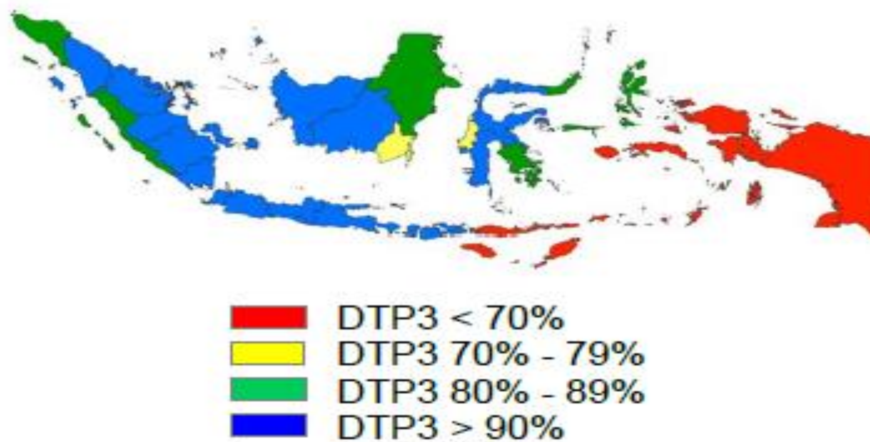
The performance of Indonesia's immunization program has stagnated over recent years. The country has been consistently reporting 84% DTP3 coverage, but the 2012 DHS shows DTP3 coverage at 72%, missing the 2010-2014 cMYP target of 95%. WHO/UNICEF estimate is 63%. (please refer to discussion on Data Quality, below). Administrative data for 2012 show DTP3 coverage of >80% in 79% of districts (392/497).

DTP1 to DTP3 dropout is 16% based on the DHS. Indonesia started intensification of routine immunization (IRI) in 2012. One of the major IRI activities is dropout-follow up (DOFU), conducted in 36 districts of 11 provinces in 2012 and in 58 districts of 22 provinces in 2013.

There is almost no difference in immunization coverage by sex, (2012 DHS: M 73% DTP3, F 71% DTP3), but a big gap in coverage levels between wealth quintiles (85% in the highest; 52% in the lowest) and also wide geographical variation between provinces, with several, such as Papua (35%) and West Sulawesi (58%) being far from their targets. The hard to reach areas are either in remote, sparsely populated eastern provinces (see Figure 3, below), or in urban slums.

Figure 3: DTP3/Penta 3 Coverage by Province, 2012

Source: SEAR annual EPI reporting form, 2012 (administrative data)



The US$ 24.8 million HSS grant is underperforming and it is not possible to assess the extent to which it has contributed to immunization outcomes. (please refer to HSS Section, below).

In contrast, Indonesia should be commended on its efficient rollout, beginning in August 2013 in 4 provinces, of Pentavalent vaccine on an accelerated national schedule of 2 years (compared to 4 years for the rollout of tetravalent vaccine). This rollout was extended on schedule to the remaining 29 provinces in May 2014. This is expected to result in immunization of an additional 2 million children.

3. Governance

Indonesia has management and communication issues typical of a very large decentralized country, and governance is weak. The ICC merged with HSCC in 2011. The ITAGI provides reliable policy advice, and there is oversight by a well-functioning National Regulatory Authority (NRA). However, there are inadequate coordination mechanisms between EPI and MCH and with development partners, and the HSCC only meets to discuss GAVI HSS support.[1]

Likewise, GAVI's 2013 Cash Programme Audit[2] found that although HSCC participation is inclusive (MoF, MoH EPI and MCH, Ministry of Foreign Affairs, BPKP (Government Auditor), DG of Pharmaceutical and Medical Devices, CSOs and International Agencies WHO and UNICEF), that it meets irregularly. Minutes are recorded but decisions are not implemented and there is no follow-up. The CPA recommendation was to strengthen the HSCC's oversight and inter-departmental coordination mechanisms with MCH and including development partners. This has not occurred.

4. Programme Management

The decentralized nature of the administration adds significant complications to effective management. Oversight of the new vaccine support is adequate, but management of the HSS Grant, which is shared between EPI and MCH, is weak. Staff roles and accountability in this

[1] Joint National and International EPI and VPD Surveillance Review, Report of the mission, Indonesia, 10 -21 June 2013

[2] Cash Programme Audit Report, HSS, CSO type B and NVS for self-procurement 2008 – 2012 GAVI Secretariat, Geneva, Switzerland FINAL – July 26, 2013

decentralized system are ill-defined and delivery of immunization services at sub-national level is inefficient. Annual indicators and targets are poorly defined and it is unclear who is accountable for achieving them. Busy midwives, under supervision of the MCH programme rather than EPI, may not prioritize immunization.

In terms of HSS implementation, the same activities are repeated, on schedule and within budget, year after year. Annual reporting remains at the level of process indicators. APRs, whose HSS reporting is almost indistinguishable from one year to the next, repeatedly report increasing coverage and all targets met and do not document any lessons learnt.

Both the MoH and partners agree that the budgeting process is complex, and for GAVI, funds transfer from the center to the sub-national level remains opaque. EPI budgets and supervision functions are centralized while surveillance and MCH budgets are controlled at province and district levels. This is a real difficulty for the EPI in managing its resource allocation and tracking of expenditures.

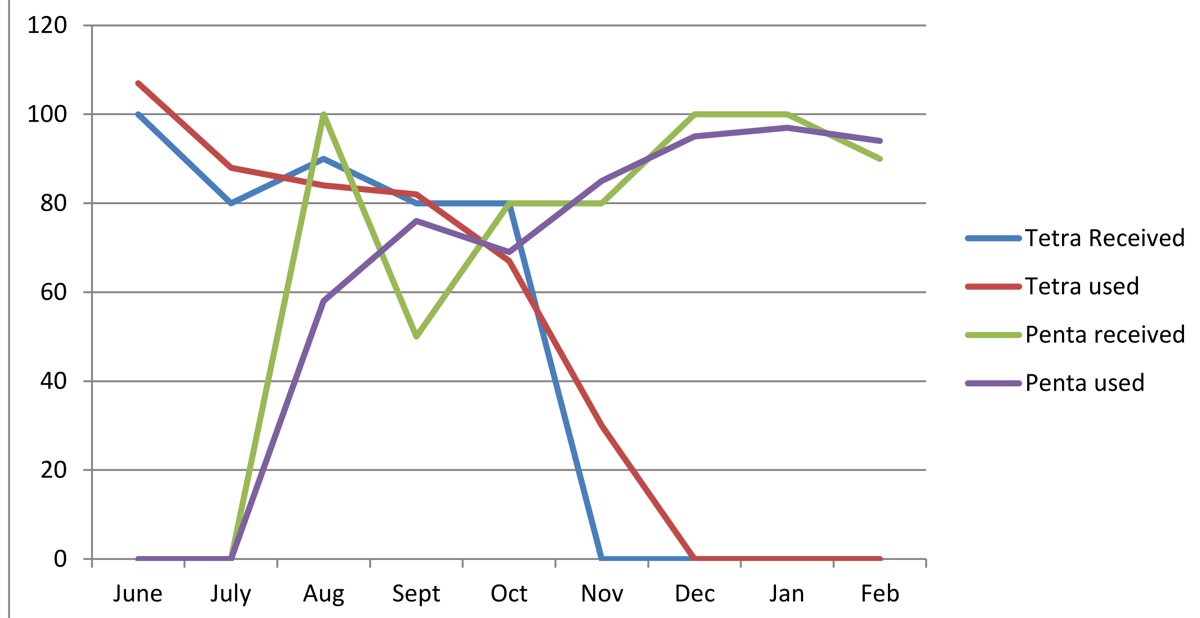
5. Programme Delivery

Primary health care services, including immunization, are delivered by Integrated Service Posts (Posyandu). The Posyandu system has generally performed well since its introduction in the mid-1980s, although there are weaknesses in supervision and accountability for efficient delivery of immunization services. There is also a brief window available for immunization of children at Posyandus, generally a half day per month, which is often announced at short notice.

BioFarma production site acts as the National cold store and supplies the 33 provinces directly. The EVM assessment concludes that BioFarma performance is strong, with solid and reliable support for vaccine cold chain logistics. Vaccine distribution under the responsibility of provinces and districts is weaker. The overall system generally ensures adequate supplies of vaccines and syringes at all levels, though delays in the contracting process have occasionally led to stock-out of vaccines in some provinces in the early part of the year. At district and health center level, much of the cold chain equipment requires replacement. A cold chain inventory and replacement plan is underway.

Pentavalent Rollout

This has proceeded well during the ten months since introduction in 4 initial provinces. During the partners' district visits in March 2014, health workers reported that the transition from Tetravalent to Pentavalent vaccine has been well accepted by mothers and that demand is high. Adequate vaccine supply is available at peripheral level. Data collected during the March 2014 field visit from a district in one of the four provinces confirm the rapid transition from Tetra to Penta, as shown in the graph below (courtesy of WHO).



Rollout to the remaining 29 provinces began as planned in May 2014, and is proceeding on schedule. There will be 100% transition from Tetra to Penta by December 2014. Indonesia is using a 5 dose vial for Pentavalent (instead of 10). The WHO recommended opened multi-dose vial policy has not yet been adopted, and vaccine wastage rates are currently estimated to be around 30%.

Co-financing obligations are being met and are able to be tracked in detail from BioFarma purchase orders, which are regularly provided to the Secretariat by the EPI Manager. Co-financing receipts submitted in December 2013 show that Indonesia fulfilled its 2013 requirements. There are no significant concerns with Indonesia's ability to co-finance since there is a well-established track record of self-financing and vaccine productions, and GAVI's funding is relatively small over a 10 year time frame, and highly catalytic.

Chronology of Pentavalent Support:

Vaccine Introduction Grant (VIG) – total: US$ 3,791,000.

50% disbursed before WHO pre-qualification of vaccine	May 2013
WHO pre-qualification obtained	June 2013
Remaining 50% VIG disbursed	July 2013
NVS funds for local tender for 4 provinces provided US$ 6,546,000	July 2013
Roll out in initial 4 provinces (12% of birth cohort)	August 2013
NVS funds for Jan 14 tender for 29 provinces disbursed: US$ 20,453,500	Dec 2013
Tender issuance (local 1 year tender)	Jan 2014
Tender award	March 2014
Roll out in remaining 29 provinces	May 2014

Cut-off date for disbursement for 2015 procurement: US$ 13,843,500)	*Dec 2014*
Tender for 2015	*Jan–Mar 2015*
Supply commences	*Apr – May 2015*
In country mission (program review and grant reconciliation)	*May 2015*

6. Data Quality

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

Regular house-hold surveys to validate coverage are conducted, but they lack standardization in survey methods, and there is large variation in coverage estimates between administrative data and surveys and between surveys themselves. In 2011, there was a >20% discrepancy (84% versus 63%) between administrative and WHO/UNICEF DPT3 estimates. The DHS report from 2012, has now been finalized and shows coverage lying between the two extremes at 72%.

Improvement of coverage data improvement activities and active surveillance systems for vaccine preventable diseases are planned but their implementation is lagging. The 2015 HSS Grant activities include planning for DQSs in 31 focus districts. It may be useful to consider a comparative analysis between HMIS and EPI data to help inform a better integration and harmonization of the two.

7. Global Polio Eradication Initiative, if relevant

The last case of indigenous wild poliovirus in Indonesia was in 1995 in East Java province. The last case of polio occurred in February 2006, related to a large outbreak due to a case imported from West Africa.

8. Health System Strengthening

Implementation of the US$ 24.8 million 2008-09 HSS grant continues to be problematic and there have been substantial delays. As of June 2014, six years after inception, it is still only 62% disbursed. This underperforming grant has become stalled in a cycle of delayed submission of APRs and resulting late disbursement of funds.

The grant was originally focused on MCH activities and civil society organizations. Following GAVI Board guidance, it was retrofitted to support immunization outcomes. This change in programme design led to a certain lack of clarity about HSS within MoH. In addition, the grant has been constrained by high management costs at central levels, where much of the funding has been spent on staff salaries, and weak implementation in targeted provinces. GAVI's 2013 Cash Programme Audit confirmed that management costs remain high at central levels (there is a Programme Management Unit, known as the 'GAVI Secretariat' with over 60 staff on salaries or top-ups).

The quality of the reporting of HSS results has been poor, consisting largely of lists of activities carried out with percentage completion rates. Where an activity has been 100% implemented, it is reported on as successful. Activities include visits, trainings, meetings, workshops, outreaches and printings. There is no mention of intermediate indicators, and it is difficult to draw conclusions on the effectiveness of all this activity. Challenges to implementation are not clearly identified.

A partner's mission in March 2014 attempted to address the Grant's underperformance, by working with the MoH to encourage more strategic thinking on future HSS activities. Following this, much work by the GAVI and EPI teams at the Ministry of Health, in consultation with WHO and UNICEF, went into revising the activities in the HSS workplan (US$ 9.4 million) to make them

more effective. The HSCC agreed to a plan for 2015-16 to focus on 31 districts with low coverage and high childhood mortality. These districts contain almost 20% of the annual birth cohort of 4.6 million, and most of these are in densely populated urban poor areas. As mentioned in the Data Quality Section above, baseline coverage surveys in all 31 districts will provide much-needed concrete objective information on where coverage is lower than desired and hopefully why.

In recognition of the low coverage in some remote eastern areas mentioned in Section 2, there are some proposed activities beyond the 31 focus districts such as the SOS implementation in remote areas and DQS in many districts. Focusing on problem districts for most of the activities is more realistic and likely to result in real improvements rather than spreading the activities out more broadly, and the baseline surveys will also make monitoring and evaluation more feasible.

This re-focussing of the programme's activities goes some way to putting Indonesia's HSS programme back on track and unblocks disbursement of the final tranche of HSS funding of US$ 9.4 million that was recommended for approval by the IRC in October 2013.

A graduation assessment mission will be carried out in in late 2014/early 2015, to guide the next HSS grant proposal of US$ 40 million for 2015-16. An end of and an end of grant assessment is also planned.

9. Use of non-HSS Cash Grants from GAVI

VIG for Pentavalent was disbursed in two tranches in 2013 and was appropriately used for the initial rollout in 4 of 33 provinces.

10. Financial Management

A Cash Programme Audit (CPA) for 2008-2012 HSS, CSO Type B and NVS for self-procurement carried out in early 2013 found no evidence of financial irregularities and concluded that the Ministry of Health had put in place the majority of control procedures outlined in the Aide-memoire resulting from GAVI's Financial Management Assessment. The report will be published on the GAVI website.

There is a difference of IDR 132,591,239 (approx. $US 11,692) between the closing balances of the 2012 financial statements and 2012 APR (IDR 712,199,901 /approx. $US 62,805) and the opening balance in the 2013 financial statements and 2013 APR (IDR 579,608,662 / approx. US$51,113), which the country has been requested to explain.

A certified English translation is awaited of the entire 2013 audit report. In future, audit reports should be communicated in English (official translated version).

The Partnership Framework Agreement has been under negotiation for over a year and is still not signed.

11. NVS Targets

The target number of infants in 2015 is 4,734,534 infants in 2015 (source grant agreement between GAVI Secretariat and MOH signed off by EPI manager May 2013). This number remains valid for this grant renewal, since it is part of the current 4 year co-financed plan which finishes end 2016. The target reflects the full cohort being reached in all 33 provinces for the whole of the 2015. The 10% increased target 'rule' does not apply since there is a phased roll out.

Progress is tracking well against the plan as confirmed by EPI manager, and a detailed review of supply and demand for Penta doses being procured from the local production and used in country in 2014 is planned for early 2015. Part of this mission will be the reconciliation of the GAVI funds provided and the use of the funds for NVS procurement locally.

Indonesia is very interested new vaccines as well as the Polio endgame and will potentially introduce one vaccine a year over the next 5 years (IPV, MR, PCV, Rota and JE in endemic provinces). Indonesia has already committed to introduction of IPV and rubella vaccines in accordance with the WHA resolutions related to polio eradication and the RC resolution on

rubella control. The next cMYP (2015 – 2019) is being finalized, and will aim at scaling up immunization coverage to reach national disease control goals:

- Sustain polio free status
- By 2018, achieve measles elimination
- By 2019, reduce CRS cases by 40%
- Achieve MNTE by 2015 and maintain it

The major focus in 2014 is to improve measles first dose coverage, where DNS 2012 reveals 82-83% coverage. Financing will be an issue (estimated at US$ 75 million). Budget estimates for catch-up MR SIA have been included in the draft 2015-20 cMYP, and will be secured through domestic funds. The government wishes to obtain GAVI prices for pneumococcal vaccine at US$3.50 per dose. Rota vaccine licensure is likely in 2017. ITAGI has yet to make firm recommendations or provide advice on prioritization of new vaccines.

12. EPI Financing and Sustainability

Indonesia has been a GAVI recipient since 2002 and to date GAVI has committed US$ 123.8 million to the country's programmes, of which US$ 93.7 has been disbursed. The country has 4 years from the introduction of Pentavalent vaccine in August 2013 to prepare to fund 100% of its vaccines in the 5th year following introduction. Graduation strategy was a major aim of the GAVI and Partners' visit in March 14, and a graduation assessment mission will be carried out in late 2014, in line with the expanded approach to graduating countries approved by the GAVI Board in Nov 2013.

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

This health financing challenge for sustainability of immunization programmes is further complicated by the decentralized nature of health financing mentioned above. District governments take responsibility for their immunisation programs while the central level is responsible for supplementary immunisation activities, procurement of vaccines and syringes, technical assistance, development of guidelines, monitoring and evaluation, quality control and training.

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

These uncertainties should be weighed against Indonesia's well-established track record of self-financing and reliable domestic vaccine production, and the fact that GAVI's funding has been is relatively small over a 10 year time frame, and highly catalytic. In addition, the Minister of Health is well aware of the graduation trajectory and co-financing commitment from now until January 2017.

13. Renewal Recommendations

Topic	Recommendation
NVS	Approve funding for self-procurement of Pentavalent vaccine for Year 3 – US$ 13,843,500 for 2015.

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline

Graduation	Follow-up with country and partners the timing of the graduation assessment mission.	CRO with FS team and EPI	Q3 2014
PFA	Request the Minister of Health to address the delay in the PFA signing.	CRO	Q3 2014
Data Quality	Followup on planning for district level DQSs that are included in the HSS Grant’s 2015 activities	CRO with EPI and WHO	Q4 2014