Memorandum on the Republic of Indonesia Programme Audit report

The attached Gavi audit report sets out the conclusions of the programme audit of Gavi's support to the Government of the Republic of Indonesia's national immunisation programme.

The audit was conducted by Gavi's Programme Audit Team in November 2017 and February 2018 and reviewed the period 1 January 2014 to December 2016, with a scope covering programme activities during that period. The final audit report was issued to the Indonesian Ministry of Health (MOH) on 19 July 2019.
The report's executive summary (pages 3 – 5) sets out the key conclusions, the details of which are set out in the body of the report. These included:

- There was an overall rating of partially satisfactory (page 3) which means that: "internal controls, financial and budgetary management processes were generally established and functioning and needed improvement. Several issues were identified that may negatively affect the achievement of the objectives of the audited entity."
- Seventeen issues were identified, most of which related to non-compliance with the financial management arrangements governing Gavi cash grants.
- Key findings were that:
    a. There were significant delays in implementing the Health System Strengthening grant, provided by Gavi in 2008, to increase and sustain immunisation coverage.
    b. During the period 2013-2016, the country's programmatic achievement was significantly challenged as its DTP3 coverage declined from 85% to 79%.
    c. The country opted to delay the introduction of several new vaccines into its immunisation programme using the Gavi support available, in part due to constraints from existing national regulations.
    d. National assurance mechanisms were weak as the MOH's Internal Audit unit did not recognise any of the Gavi-provided funds in its scope and the MOH did not adequately follow up on the external audit recommendations; and
    e. The MOH's budgetary financial management controls were not effective, as expenditures funded by Gavi grants were not consistently substantiated, recorded, and archived.

The Ministry of Health and Gavi agreed that the Ministry's Inspectorate General function would review additional supporting documentation which was not available at the time of the audit. In January 2019, the Inspectorate General concluded that most of the supporting documentation was now available and on file, except for that relating to still-questioned expenditure of US$ 71,060.

The results of the programme audit have been discussed with the Ministry of Health, who have agreed to remediate the identified issues and indicated that they accept the principle of reimbursing US$ 71,060 to Gavi. Gavi is therefore writing to request that the MOH repay that amount. The Gavi Secretariat will continue to work with the Ministry of Health to ensure that these commitments are met.

Geneva, 9 November 2020

REPUBLIC OF INDONESIA

Programme audit of Gavi Support to the Ministry of Health

Gavi Secretariat, Geneva, Switzerland

Final Programme Audit Report – 19 July 2019

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1 Executive Summary

Gavi's Programme Audit unit conducted an audit of Gavi's cash and vaccines support to the Government of the Republic of Indonesia's Ministry of Health (referred to as MOH hereafter). The field work for this audit took place between 23 October and 10 November 2017. At the request of the MOH, the Audit Team conducted supplementary work in February 2018, to review supporting documentation which was not earlier made available to the Audit Team.

Gavi support were managed by four different Directorates of the MOH: Disease Prevention and Control; Health Promotion; Public Health; and Pharmaceutical and Medical Devices.

The audit scope covered Gavi-supported programme activities implemented by the MOH during a three-year period: 1 January 2014 to 31 December 2016. During this period, Gavi disbursed a total of USD 51,571,000 to the MOH, for details see Table 11 in Annex 4. The total expenditure reported for the same period was USD 40,354,523 (IDR 516 billion), for annual breakdown see

Table ***12*** in Annex 4 . The Audit Team reviewed transactions totalling USD 30,079,026 (IDR 385 billion) covering 75% of the period's expenditures.

Audit rating

The Audit assessed the management of Gavi-provided funds for above-mentioned programmes as *partially satisfactory*, which means "internal controls, financial and budgetary management processes were generally established and functioning and needed improvement. Several issues were identified that may negatively affect the achievement of the objectives of the audited entity". This rating was mainly due to the deficiencies noted in the internal control system, and the failure to achieve objectives of a programme supported by Gavi funds.

Key issues

The table below summarises the Audit Team's ratings for each of the areas reviewed:

Table 1: Summary of audit focus areas rated by programme audit

Area	Audit Rating
Programmatic achievement	Unsatisfactory
Vaccine and supply chain management	Satisfactory
Financial management and expenditure control	Partially satisfactory
In-country oversight mechanisms	Partially satisfactory
Overall rating	**Partially satisfactory**

Implementation of Pentavalent NVS grant	Between 2013 and 2016, in lieu of Gavi's procurement agent sourcing vaccines from the international market, Gavi provided an equivalent of USD 44 million cash support to the Government of Indonesia (GOI), for it to procure pentavalent vaccine from its WHO-approved domestic manufacturer. The GOI successfully managed this funding, and achieved savings totalling USD 8.4 million by negotiating a cost-effective pricing structure with the manufacturer. These savings have been earmarked for the MOH's national immunisation programme, as required. Since the end of 2016, the GOI continues to fully finance and meet its national pentavalent vaccine requirements.

Programmatic achievement	The country missed out on introducing several new vaccines in its national immunisation programme with Gavi support at a negotiated price while it was still eligible for the support. Though the country did take the opportunity of Gavi support during the final years of eligibility for pilot introduction of MR, IPV, HPV and JE vaccines, these vaccines were yet to be offered in the nationwide routine immunisation schedule. There still remains an opportunity for the GOI to access favourable price for select new vaccines if they are procured from UNICEF Supply Division. These prices are on offer by the respective vaccine manufacturers for a limited duration. However due to national regulations, the MOH is constrained in the choice of vaccine suppliers that it can procure from. Unless the GOI addresses these constraints, the MOH will continue to face higher commercial prices which may impede its ability to introduce several new vaccines in next 3 – 4 years, as it plans. Also, it was noted that Indonesia's DTP3 coverage declined[1] from 85% in 2013 to 79% in 2016. There were significant delays in implementation of Health System Strengthening (HSS) grant, provided by Gavi in 2008, to increase and sustain immunisation coverage.
Vaccine and supply chain management	There were not enough monitoring and supervision visits from the central level to the provinces, so as to address weak vaccine management practices. There was no suitable system in place to accurately consolidate vaccine data, so as to provide visibility on the status of stocks across the country. Similarly, insufficient data was available on vaccine wastage rates and on the inventory and status of cold chain equipment. From select site visits, the Audit Team noted that vaccine records were not always complete or properly maintained.
Financial Management & Expenditure Control	At the central level, there was no credible process in place to monitor budgetary progress against performance – and given that annual work plans were not implementation unit-specific, the plans were not an effective tool to control and direct budgeted activities. At the central and provincial levels, expenditures funded by Gavi grants were not properly substantiated, recorded and archived - and were not subject to the national financial management controls and systems. Implementing units undertook the vast majority of payments in cash, without adequate financial supervision and monitoring. Supporting documents were not adequately referenced, and it was not evident how the financial statements were prepared from the underlying records. As a result, and in recognition of the need that records needed to be reconstituted, following the end of its fieldwork in 2017, thereafter Audit Team engaged the Inspectorate General of Ministry of Health throughout 2018, for them to audit the remaining outstanding expenditures. Ultimately, expenditures **totalling USD 71,060** were questioned based on the audit work conducted.
In-country oversight mechanisms	Satisfactory governance functions were undertaken by the Inter-agency Coordinating Committee and external audits by the country's Supreme Audit Agency. In contrast, the MOH's Internal Audit unit did not provide assurance on Gavi-provided funds, as these monies were not included in its scope. Instead the unit gave priority to auditing those programmes funded by planned grants and the

[1] As reported in WHO Joint Reporting Form, coverage refers to the number of administered doses divided by the number of eligible children to receive that vaccine.

national budget. The MOH did not promptly follow up and address all of its outstanding external audit recommendations.

To address the above issues, the Audit Team has made 18 recommendations, of which 4 are rated critical, which means that action is required to ensure that the programme is not exposed to significant or material incidents. Failure to take action could potentially result in major consequences, affecting achievement of the programme's overall activities and output.

The recommendations were prioritised as either critical, essential or desirable, and definitions of the three-levels of prioritisation are summarised in **Annex 1.**

The table below provides a summary of transactions questioned by the Audit Team, which were either: (a) inadequately supported, or (b) completely lacking support documentation. **See Annex 2** for definitions of these categories.

Table 2: Breakdown of questioned expenditures

Category	Location	IDR	USD	Report Section
Ineligible expenditure	Central Level	8,400,000	631	**5.3.6**
Irregular expenditure	Central Level	260,000	22	
Unsupported expenditure	Central Level	829,352,964	67,130	
Ineligible expenditure	Province Level	32,870,000	2,470	
Irregular expenditure	Province Level	10,684,000	806	
Total		**881,566,964**	**71,060**	

2 Objectives and scope

Objectives

As stipulated in Gavi's Transparency and Accountability Policy, the main objective of a Programme Audit is to: obtain evidence that funds were used for intended purposes and in accordance with the agreed terms and conditions; and to help identify opportunities to improve management of Gavi funded programmes. To achieve its objectives, the audit assessed: the MOH's internal controls; the reliability and integrity of managerial and operational information; the effectiveness of operations; the safeguard of assets; oversight arrangements; and compliance with relevant national policies and procedures.

Scope

The scope of the audit covered the MOH's management of the immunisation programmes; vaccine management; income received, and expenditure incurred; fixed asset management; and procurement, for the period from 1 January 2014 to 31 December 2016, as financed using Gavi support. For the period subject to this audit, the MOH reported USD 40,354,523 (IDR 515,962,349,922) of Gavi related expenditure. See

Table ***12*** in Annex 4.

Expenditures at the provincial level were also reviewed which was guided by risk-based sampling based on the nature and materiality of the expenditures. Across 33 provinces, total expenditure reported for the audit scope period was USD 4,102,502 (IDR 52,412,163,243). Two provinces selected for the review, Jawa Timur and Sumatera Barat, had a combined reported expenditure of USD 690,213 (IDR 8,903,401,652), representing 17% of the overall expenditure reported for all the provinces for the period 2014-2016.

Additional work undertaken by the Ministry of Health Inspectorate General

In February 2018 at the end of the Programme Audit fieldwork, the Gavi Audit Team concluded that several of the Ministry of Health implementing units had been unable to present expenditures totalling IDR 10.4 billion (USD 797,938).

Therefore, in April 2018 the Ministry of Health and the Audit Team agreed that the Inspectorate General (IG) would audit the outstanding expenditures. Throughout 2018, the MOH IG therefore proceeded to review the remaining supporting documents. This included for them to have to reach out to the remaining implementing units, in particular the Directorate General for Public Health (which accounted for approximately 83% of the outstanding amounts) and monitor their progress in reconstituting the necessary records. Thereafter, the Inspectorate General was able to audit the additional expenditures for the three outstanding implementing units and two provinces, respectively. The IG's review was undertaken in accordance to the terms of reference provided by Gavi.

At the start of 2019, the Inspectorate General completed its work and ultimately submitted final conclusions and reports to Gavi in July 2019. Sections 5.3.6 and 5.3.7 of this report incorporate the MOH IG's findings.

Exchange rates

For the purposes of this report, all amounts denominated in the Indonesia Rupiah (IDR) were converted using the following rates:

- For 2014, an average rate of USD 1 = 11,879 IDR;
- For 2015, an average rate of USD 1 = 13,392 IDR; and
- For 2016, an average rate of USD 1 = 13,307 IDR.

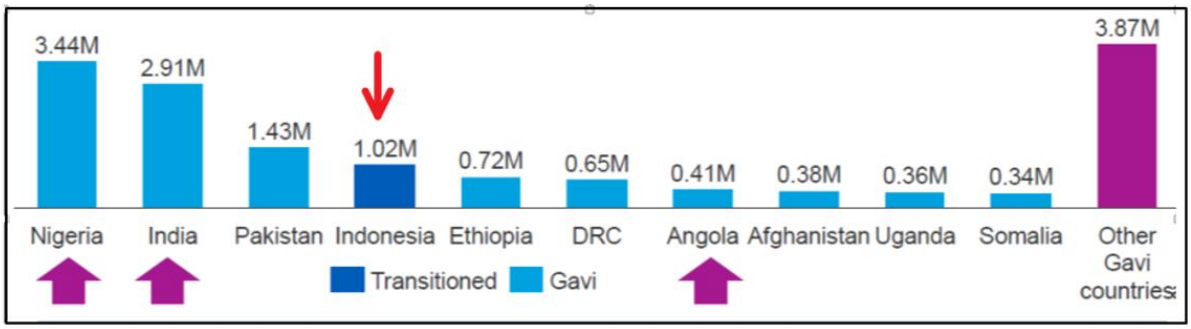
Due to the exchange rate fluctuations between the financial years subject to Programme Audit, the Audit Team applied an average rate for each financial year. The average exchange rates were computed based on the published rates of the Central Bank of Indonesia during the period 1 January to 31 December each year.

3 Background

Indonesia is the world's fourth largest country by population. The country has an annual birth cohort of almost five million. On one hand, remoteness of some of the islands means that they receive infrequent medical services. On the other hand, urban slums such as in Jakarta are experiencing explosion of population and therefore presenting as a challenge in reaching out to the growing new communities.

According to WHO estimates, approximately 19.5 million infants worldwide every year miss basic vaccines.[2] Around 60% of these children live in 10 countries, namely: Angola, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Iraq, Nigeria, Pakistan and South Africa. In Indonesia, annually 1.02 million children do not receive basic immunization.

Figure 1: Countries with the highest number of unimmunised children.



Indonesia's GDP per capita has risen, from $857 in the year 2000 to $3,603 in 2016. It is the world's 10th largest economy in terms of purchasing power parity, and a member of the G-20.[3]

The public health system in Indonesia is administered in line with the decentralized government system in Indonesia, with central, provincial and district government responsibilities. The central Ministry of Health is responsible for management of some tertiary and specialist hospitals, provision of strategic direction, setting of standards, regulation, and ensuring availability of financial and human resources. Provincial governments are responsible for management of provincial-level hospitals, provide technical oversight and monitoring of district health services, and coordinate cross-district health issues within the province. District/municipal governments are responsible for management of district/city hospitals and the district public health network of community health centres (puskesmas) and associated sub district facilities.

The six essential public health services in puskesmas consist of: health promotion; disease control, including immunization and surveillance; ambulatory care; maternal and child health; and family planning; community nutrition; and environmental health, including water and sanitation. The local governments through puskesmas and their networks are responsible for the delivery of immunization programmes in their areas. In order to ensure effective management of the immunisation programme, the Government has issued a decree which aims to regulate the implementation of the national policy on immunisation programmes throughout the country from national to subnational level.

[2] Source: http://www.who.int/mediacentre/factsheets/fs378/en/, accessed 8 December 2017.
[3] Source: http://www.worldbank.org/en/country/indonesia/overview, accessed December 2017

The national immunisation programme offers immunisation coverage for all children aged 0-1 years against eight diseases: BCG, polio, measles, diphtheria, pertussis, tetanus, hepatitis B and haemophilus influenza type B vaccine (for pneumonia and meningitis). In 2013 the Government, with support from Gavi, introduced a new Pentavalent vaccine, distributed by Bio Farma, a national vaccine supplier. Pentavalent contains five antigens in one shot and provides protection against diphtheria, pertussis, tetanus, hepatitis B and haemophilus influenza type B.

Gavi grants

Since 2002, Gavi has been providing the GOI with new vaccine support for hepatitis B mono vaccine4, pentavalent and inactivated polio vaccine; and most recently human papillomavirus, Japanese encephalitis and measles rubella. During the same period, Gavi also provided cash grants for Health Systems Strengthening, Civil Society Organisation Support, Immunisation Services Support and Injection Safety Support. As of May 2017, the total value of the vaccine and cash support provided by Gavi for the immunisation programmes in Indonesia was USD 159.8 million, for detail see

*Table **13*** in Annex 4.

Implementing Units

Gavi-provided funds were implemented by the MOH through four of its directorates whose assigned roles were as follows:

- Directorate General for Disease Prevention and Control (DGDPC) – The Directorate General for Disease Prevention and Control took responsibility for Health Systems Strengthening (HSS) component activities as well as Immunisation Services Support (ISS) and the Vaccine Introduction Grant (VIG) components of the Gavi-funded Programmes. Activities of this implementing unit were undertaken at both central and subnational levels.
- Directorate General for Pharmaceutical and Medical Devices (DGPMD) – The Directorate General for Pharmaceutical and Medical Devices took responsibility for the New Vaccine Support (NVS) component of the Gavi-funded Programme including the procurement and logistics of vaccine distribution from 2015 onwards.
- Directorate General for Health Promotion (DGHP) – The Directorate General for Health Promotion took responsibility for the Civil Society Organisation (CSO) component of the Gavi-funded Programme and parts of the Health Systems Strengthening (HSS) component from 2015 onwards. The CSO function of this implementing unit no longer exists due to this component of the Gavi-funded Programme ending in 2015.
- Directorate General for Public Health (DGPH) – The Directorate General for Public Heath took responsibility for the Health Systems Strengthening (HSS) component of the Gavi-funded Programme. Activities of this implementing unit were at a central level.
- Programme Management Unit (PMU) – Each Implementing Unit (IU) had a PMU to manage Gavi funds and programmes.
  - Secretariat for Coordination and Integration of Gavi Immunization Program (SKIPI Gavi) – Responsible for coordination of the PMUs from the IU. SKIPI Gavi was housed within the offices of DGDPC.

Key challenges

[4] Since 2013 hepatitis B mono became part of pentavalent vaccine combination.

- It is challenging for the DGDPC unit to secure adequate domestic funding for the Indonesian immunisation programme for the coming years because health programme expenditures are likely to increase significantly. The primary drivers for the increased expenditure is the GOI's planned introduction of four to five new vaccines in its routine immunisation programme within next the three to four years. These introductions coincide with a time when the country will no longer be eligible for Gavi support; and the GOI's ambitious national health insurance system[5], which aims to provide universal coverage by 2019.
- Decentralised Health Programmes: With a high level of decentralisation in Indonesia, delivery of health programmes is the responsibility of the subnational level, with no direct intervention from the central level. This decentralisation presents challenges for standardising immunisation practices across the 34 provinces. Further, in the absence of oversight responsibilities between the subnational entities and central MOH, monitoring of the subnational performance is difficult; and the central MOH has a limited capacity to directly implement activities at the subnational level.
- There are sovereign restrictions on the purpose for which provinces are able to access Gavi funds for their use. For example, all provincial operational cost for immunisation activities are required to be covered by the province's respective budgets which are funded by the central government. In the past, provinces have under-spent funds provided by the centre and in response the government set strict expenditure targets. This has led to prioritisation on the use of the funds provided by the central government over those from donors.
- The topographic and disparate nature of the geographic spread of Provinces/Districts: Indonesia continues to be challenged by hard to reach populations based in isolated provincial areas such as remote, sparsely populated eastern provinces, mountainous and small island communities and urban slums.

[5] Locally known as Jaminan Kesehatan Nasional.

4 Gavi's Support for Pentavalent vaccines successfully achieved long-term programmatic and financial sustainability

By Gavi's definition, countries with an average Gross National Income (GNI) per capita below or equal to USD 1,580 over the past three years, are eligible for New Vaccine Support (NVS). Those countries which receive NVS are required to co-finance a portion of the vaccine cost. When the average GNI per capita exceeds this eligibility threshold for a period of three consecutive years, the country enters a transition phase which usually lasts an additional five years. During this transition period, Gavi requires the co-financing obligation to proportionately increase each year, with the objective that at the end of the transition, the country is expected to fully self-finance its vaccines.

Between 2013 and 2016, Gavi supported the GOI with USD 44 million to self-procure pentavalent[6] vaccines. Given that Indonesia was a transitioning country since 2013, it was required to increasingly finance a portion of its annual pentavalent vaccine requirement. With funds provided by Gavi and the GOI's own funds, the MOH procured pentavalent vaccines and associated injection safety devices from PT Bio Farma (Bio Farma) which is a state-owned enterprise based in Bandung, Indonesia. The arrangement for domestic self-procurement was agreed between Gavi and the GOI. The locally manufactured vaccine meets International standards and is WHO pre-qualified. This arrangement is atypical from other Gavi supported countries, most of which receive vaccines directly from Gavi's procurement agents, typically the UNICEF Supply Division.

Since 2013, each year, the MOH and Bio Farma entered into contracts for the production and distribution of pentavalent vaccines. Bio Farma delivered the vaccines directly across 33 Provincial Vaccine Stores in accordance to a distribution schedule provided by the MOH.

The Audit Team reviewed the contract and delivery documents for pentavalent vaccines supplied by Bio Farma and confirmed that the GOI met all of Gavi's stipulations as defined in the NVS grant for Pentavalent. The distribution records included a *packaging slip* including pertinent vaccine details such as: the issuance date, batch number, quantity, cost per vial of the vaccine and receipt acknowledgement by representatives from the Provincial Health Office. The Audit Team also visited and verified delivery at three Provincial Vaccine Stores.

Table 2: Total Pentavalent doses procured during the period 2013 – 2016 with Gavi and GOI funds

2013 - 2016	Gavi Funds	GOI funds (Co-financing)
Number of doses required to be procured	28,702,400	34,574,300
Number of doses actually procured	28,722,400	32,546,435
Compliance	**>100%**	**94%**

At the end of 2016, Indonesia fully transitioned out of Gavi support, i.e. the country was no longer eligible for Gavi support. Since the beginning of 2017, the GOI has been successfully financing all of the national demand for pentavalent vaccine from its national immunisation programme. This is a good example of a country's commitment to take over activities initiated with Gavi support. In addition, since Pentavalent is produced locally in Indonesia and at a competitive price, this programme is financially sustainable.

[6] A single dose of vaccine containing antigens for Diphtheria-Tetanus-Pertussis -Hepatitis B-Haemophilus influenza type b. In Indonesia, locally produced DTP-HB-Hib vaccines is named Pentabio which is also known internationally as Pentavalent.

5 Detailed findings

5.1 Programmatic achievement

Introduction

Gavi support to the GOI technically ended in December 2016 when the country transitioned to fully self-financing status. In 2017, on an exceptional basis, Gavi provided the country with an additional USD 34.9 million as exceptional catalytic support for new vaccine introductions. See

Table 14 in Annex 4.

5.1.1 Insufficient and declining DTP3 coverage

The 2020 Global Vaccine Alliance Plan's target is to reach 90% national coverage and 80% in every district or equivalent administrative unit for all vaccines in every national programme. A similar measure of success for an immunisation programme is when a country is able to both achieve and sustain a DPT3 coverage of 90% for at least three years.

According to WHO/UNICEF data, DTP3 coverage in Indonesia was 79%[7] in 2016, which is below the global target. Moreover, data shows that the coverage has declined from 85% in 2013 to 79% in 2016. In addition, Indonesia has the fourth largest population of unimmunised children in the world, see ***Figure 1 in*** *section 3 of the report.* The MOH has not articulated the specific causes for such a decline, however, the fall in coverage coincides with the introduction of pentavalent vaccines. Indonesia is also reported to have high levels of inequality in its DTP3 coverage between richest and poorest, as well as educated and non-educated populations.[8]

The central MOH provided funds and vaccines to the provinces, which were responsible for service delivery and periodic reporting of immunisation coverage to the DGDPC at the central level. The reporting was limited to the immunisation coverage. For instance, the subnational levels were not required to submit regular financial and programme reports to the centre during the fiscal year. Such reports would have enabled the MOH to intervene when implementation of programme activities fell behind the agreed targets.

Cause

The HSS grant included mentoring and supervision activities to identify the bottlenecks to improving immunisation coverage. However, only a few supervisory visits were undertaken. The central level was expected to target districts with low coverage.

Risk/ effect

Unimmunised or under-immunised coverage can lead to increases in national morbidity rates.

Recommendation 1 - Critical

In the event of future Gavi support, the MOH working with 'high-risk' districts, should take specific time-bound actions to identify and address bottlenecks to achieving the coverage targets. The actions developed should be included in a multiyear workplan with focus on districts with low coverage and a large number of unimmunised children. Also, the central and sub-national levels should agree regular

[7] Coverage per country's official estimates, for the same period, is at 84%.

[8] Based on Indonesian Demographic and Health Survey 2017.

reporting and monitoring arrangements for the work plans, as well as interactions for remedial actions on missed targets.

Management response in Annex 5: Management Comments and Action Plan

5.1.2 Several primary vaccines have not yet been introduced

In Indonesia, primary childhood vaccines such as pneumococcal, rotavirus, and human papillomavirus vaccines have not yet been introduced into the national immunisation programme.

The GOI intends to introduce 4 – 5 new vaccines in its routine immunisation programme within the next 3 – 4 years. Though Indonesia has reached a fully transitioned status, the country is still eligible to procure some primary vaccines at favourable prices through UNICEF Supply Division. However due to national regulations, the MOH faces several obstacles in procuring vaccines from UNICEF. The manufacturers of the vaccines have offered these negotiated prices for a limited duration and therefore there's a need for the GOI to assess the situation and establish a mechanism which permits the MOH to procure the new vaccines expeditiously and most economically.

Delay in vaccine introduction

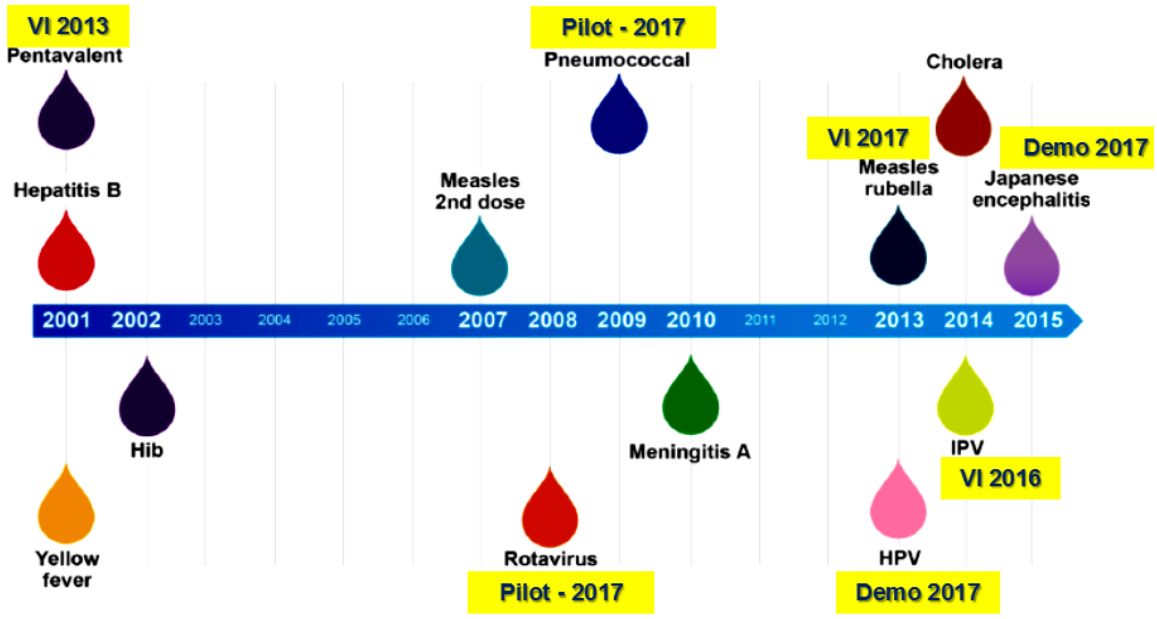
During the period 2007 – 2016, Indonesia was eligible for extensive Gavi support to introduce a range of vaccines including PCV, Rota, MR, Men A, HPV, IPV and JE. However, as of 2016, the MOH had not establish these vaccines into its routine immunisation programme and Gavi's offer of support has since lapsed.

According to UNICEF, Indonesia had 25,000 pneumonia-related deaths in children under five in 2015[9] but the country has not yet introduced PCV in its routine immunisation schedule.

In 2017, based on the GOI's own funds and Gavi support, the MOH had undertook limited-scope programmes to pilot the introduction of four additional non-routine vaccines, namely Rota, PCV, IPV and JE. The country also received Gavi support for MR campaign and subsequent introduction of the vaccine in the routine immunisation schedule at the selected provinces. For the remaining provinces, the country plans to undertake another MR campaign in 2018 followed by introduction in the routine immunisation schedule. Except for the MR, these pilots were with a view for the GOI to potentially introduce these new vaccines over the coming 3 - 4 years.

Figure 2: Timelines showing when the vaccines were available through Gavi support vs. actual introduction

[9] Source: https://data.unicef.org/wp-content/uploads/2016/11/UNICEF-Pneumonia-Diarrhoea-report2016-web-version_final.pdf, page 26, accessed 8 December 2017.



Limitation due to presidential regulation on public procurement (Perpres) No. 54/2010

To ease the rapid domestic funding need in the immunisation programme after the countries' transition out of Gavi support, Gavi has secured negotiated vaccine price commitments from the manufacturers of vaccines. Under this arrangement, several manufacturers have committed to continue providing Gavi supported countries with access to the same price as Gavi pays, or to maintain the prices countries are currently paying for certain vaccines for set periods of time after they have transitioned out of Gavi's support. In addition, Gavi has piloted Advance Market Commitment for pneumococcal vaccines as an innovative way to make effective and affordable vaccines available in Gavi supported countries, including those that have already transitioned out of Gavi support. Technically, Indonesia is eligible to access some of the negotiated vaccine prices, but its national regulation is a deterrence in making use of this opportunity.

Typically, in Indonesia, the market price for the new vaccines is significantly higher than the negotiated price that Gavi-supported countries can access after transition; as publicly advertised by Gavi and its procurement agent, UNICEF Supply Division. The table below illustrates the approximate difference between the standard commercial market and the negotiated prices:

Table 3: Comparison of the cost of vaccines between negotiated and the commercially price available in Indonesia.

	In IDR		
Vaccine	PPU / dose UNICEF rate	PPU / dose Commercial rate[10]	Price difference
IPV	125,400	152,900	22%
PCV	43,560	300,000	589%
HPV	59,400	168,000	183%
MR	79,200	175,000	121%
JE	23,060	65,000	182%
Rota	46,200	300,000	549%

[10] As stipulated in the contracts between the MOH and the vaccine suppliers in Indonesia.

Key limitations imposed by the existing national regulations for the MOH to procure the new vaccines directly from UNICEF are:

- In April 2015, the president issued a decree establishing the e-Catalogue, an online procurement system by which government departments should source all of their products and services. In accordance to this decree, the MOH's Directorate General of Pharmaceutical and Medical Devices (DG-PMD) procured its medicines, including vaccines, from the e-Catalogue. Key suppliers in the catalogue, include Bio Farma (for Pentavalent, IPV and MR vaccines), as well as several other manufacturers' agents that offer to supply the pneumococcal and rotavirus vaccines – except for pentavalent, all other vaccines were offered at commercial prices.
- The Drugs Committee of the National Public Procurement Agency (locally known as LKPP) is responsible for managing a formal vendor selection process through which suppliers and their products can be listed on the e-catalogue. The listing process also requires that all medicine must obtain official clearance from the National Agency of Food and Drugs Control (NADFC) confirming that they meet specific national licencing requirements. Thus, only suppliers which are NADFC licenced and meet the LKPP's technical requirements can be included within the e-catalogue. Thus, as UNICEF is not registered as a trading entity in Indonesia, by default it cannot meet the NADFC and LKPP's requirements so as to be listed in the catalogue; and
- The Government's procurement regulations require that the supplier can only be paid after the respective department verifies receipt of products or services. UNICEF's standard procurement arrangements contravene this requirement, since as an agent, it normally operates on an up-front payment basis before the shipment of vaccines.

The Audit Team considers that had the country introduced some of these vaccines sooner that the current 2019 target, the vaccines may have helped to reduce the country's overall child morbidity rate. There are several precedents established where faced with a comparable situation, other countries, with the support of Gavi Alliance partners, have obtained the necessary regulatory exemptions to procure vaccines from UNICEF Supply Division.

Cause

As the GOI works towards ensuring self-reliance in health commodities, it has a preference for locally sourced vaccines in order to achieve both programmatic and financial sustainability. However, to date, Bio Farma, the local manufacturer only produces pentavalent vaccine to meet the national demand; with Rotavirus, Pneumococcal and Measles and Rubella vaccines in the pipeline. While Bio Farma has plans to produce most of the vaccines and some are already in advanced stages of clinical trials, it has no production plans for JE and HPV.

Risk/Effect

An opportunity has been missed, as a result of not promptly introducing pneumococcal and rotavirus vaccines while under Gavi-support so as to promote health from preventable diseases. In addition, there is a further risk of the GOI not being able to procure the new vaccines at negotiated prices due to restrictions imposed by existing national regulations.

Recommendation 2 - Critical

The MOH is recommended to implement a strategy to introduce some of these new vaccines while taking into consideration: epidemiological concerns; the health benefits; Bio Farma's vaccine

development and production schedule; and the commercial viability of alternative sources until local production is established.

Management response in Annex 5: Management Comments and Action Plan

5.1.3 Underutilised grants and substantial in-country cash balance

As at September 2017, the MOH had USD 11.9 million of unused Gavi-provided funds in its bank account from grants already disbursed. The unused balance comprised of: USD 8.4 million (i.e. 71%) from the savings in self-procurement of Pentavalent vaccines; and the balance of USD 3.5 million (29%) related to unspent HSS, VIG and ISS funds.

In addition, the MOH also held USD 2.36 million funds from Gavi's catalytic grants disbursed in 2017, as per ***Table 4***. The Audit Team concluded that this particular balance was not a concern, as the catalytic programme is still ongoing and the funds were likely to be fully used by the end of 2018.

Table 4: Breakdown of in-country cash balances by grant type as of September 2017 in US Dollars

Cash balance in the country with the MOH	Expected grant duration	Last tranche disbursed Year	Balance Amount
NVS - Cash for self-procurement of Pentavalent Vaccines - savings	2013 - 2016	2015	8,443,383
Health Sector Strengthening (HSS)	2008 - 2010	2015	2,259,168
VIG for Pentavalent Vaccines	2013 - 2014	2013	1,229,584
Immunisation Services Support (ISS)	2007 - 2010	2007	6,774
Subtotal Cash balance with the MOH from the grants that have passed their terminal dates			***11,938,909***
NVS - Cash for self-procurement of Measles & Rubella (MR) Vaccines	2017 - 2018	2017	2,124,058
VIG for Inactivated polio vaccine (IPV)	2014 - 2017	2017	2,074,599
NVS - Cash for self-procurement of IPV Vaccines	2016 - 2018	2017	218,380
Cash for Human papillomavirus (HPV) vaccine demo operational cost	2017	2017	170,000
VIG for Japanese encephalitis (JE)	2017	2017	93,109
VIG for MR (expenditure for which no cash was disbursed)	2017 - 2018	NA	(2,323,091)
Subtotal Cash balance with the MOH from the grants that are ongoing			***2,357,055***
Bank interest and other income		NA	1,753,794
Grand total - Cash balance with the MOH			**16,049,758**

A further USD 19 million of Gavi support was earmarked for the MOH, but was not yet disbursed as of September 2017, see

Table 5. Except for the undisbursed balance for NVS Penta grant, the remaining undisbursed grant of USD 12 million relate to ongoing programme and is likely to be spent in 2018.

Table 5: Breakdown of approved but undisbursed grant balances as of September 2017 in US Dollars

Approved but undisbursed grant balances	Expected grant duration	Balance Amount
NVS - Cash for self-procurement of Pentavalent Vaccines	2013 - 2016	6,855,500
NVS - Cash for self-procurement of IPV Vaccines	2017 - 2018	8,046,000
VIG for MR	2017 - 2018	3,915,000
NVS - Cash for self-procurement of JE Vaccines	2017	343,500
NVS - HPV Demo (procured via UNICEF)	2017	85,682
Cash for HPV demo operational cost	2017	25,000
Grand total undisbursed but approved grant balances		***19,270,682***

As at 11 Nov 2017, the MOH and Gavi's Country Programme team were still exploring ways to re-programme and spend the total grant balances of USD 20.5 million, consisting of: USD 11.9 million of grant balance in MOH's bank account, USD 6.9 million of approved but undisbursed NVS Pentavalent grant balance; and USD 1.8 million of bank interest.

The USD 15 million savings, i.e., balance with the MOH and undisbursed balance, was due to favourable pricing terms offered by the domestic manufacturer. As agreed between the MOH and Gavi these savings belong to the GOI and were to be spent on immunisation related activities.

However, the unused USD 3.5 million balance with the MOH relates to past or expired grants which are lapsed, with no concrete plans having been yet agreed on how to use these monies.

Health System Strengthening (HSS) grant

The Independent Review Committee, Gavi Alliance and Fund Boards approved the HSS grant in June 2008 to the tune of US$ 24,827,500, see ***Table 15*** for the actual disbursement schedule. The grant objective was to ensure increased and sustained immunisation coverage by addressing health system barriers and improving recording and reporting of the immunisation data.

The first tranche was transferred to the MOH in September 2008. The original proposal was to implement this grant in 18 months, i.e. from Q3 2008 to Q4 2009. USD 7,961,000 was allocated for 2008 and USD 16,866,397 for 2009. However, this disbursement schedule was altered at the request of the MOH in order to adapt to the slow pace of programme implementation.

Programme implementation only started in 2009 with utilisation of under 5% in the first year. The absorption rate for the consecutive years remained low resulting in significant grant balances were carried forward from year to year. Annual Progress reports show that funds utilisation between 2009 and 2014 was USD 12,564,581, or 51% of the total approved amount. The HSS grant was reprogrammed twice, first in 2013 and then in 2015, with the final terminal date of December 2016. However, as of July 2017, after 8 years since the first disbursement, a cash balance of USD 1.78 million still remained.

There was notable improvement in the programmatic achievement and the budget executive rate after the last reprogramming in 2015. However, the overall impact of the HSS grants remain questionable because the primary focus of the grant which was to increase the DTP-HB-Hib coverage in districts and cities with low coverage, which was not fully achieved. There was no improvement in vaccination coverage as seen by a stagnation in reported results for the period 2014 to 2016.

Analysis of the HSS spending suggest that, on average, the MOH was able to use USD 3 million every year to implement programmes. This suggest that there was disconnect between the programmatic ambition and MOH's capacity to meet the pace of implementation.

Vaccine Introduction Grant - Pentavalent

In July 2013, Gavi disbursed a VIG of USD 3.8 million to the MOH to support some of the operational costs of introducing the pentavalent vaccine. It is anticipated that such funding should be fully spent leading up to or at the time of vaccine introduction. However, as at June 2017, more than four years after pentavalent was introduced into the country's routine programme, there remains an unspent balance of USD 1.23 million (32%).

Cause

From discussion with the MOH and in-country partners, the Audit Team noted the following contributory factors to this situation:

- In Indonesia, the management of the health programmes is decentralised right down to the district level, with subnational level health services largely operating independently from the central MOH. However, it is mandated that the operational costs for these programmes is funded by the districts' own budgets, including costs for: training of the health workers; outreach activities; vaccine store running cost; cold chain equipment maintenance; vaccine distribution; and printing of information education and communication materials were. As a result, there is limited scope for the national immunisation programme to either implement immunisation activities at the subnational level, or to supplement or directly finance part of the districts' immunisation budgets.
- HSS supported activities were implemented across three Implementing Units (IUs) that effectively operated as vertical programmes which lacked an effective coordination. These IUs did not regularly meet to discuss their performance and activities. The issue of lack of coordination amongst both units was highlighted in the 2014 external audit report, but this issue was not effectively addressed.
- In Indonesia under a relatively strict financial regime, each Ministry receives its annual budget allocation, is required to also demonstrate its performance by meeting specific budget utilisation targets. The MOH's utilisation target for 2016 and 2017 was 85% and 97%, respectively. As a consequence of the MOH's necessity to meet its public expenditure targets, there was less focus on donor supported programmes, and the execution of certain activities – including those supported by Gavi – were a lesser priority.

Risk/Effect

In failing to timely utilise the Gavi-grant funds and by not implementing programme activities, the MOH missed the opportunity to improve the overall performance of its immunisation programme.

Recommendation 3 - Essential

The MOH is recommended to:

- Return unused balances totalling approximately USD 3,488,752 to Gavi for the following support grants which have elapsed: HSS and VIG-Penta.

- For: the remaining grant balance with the MOH; the bank interest income; and the unallocated funds, in discussion and agreement with Gavi and the in-country alliance partners, identify suitable investment opportunities in critical areas to improve the immunisation coverage.
- Once the investment opportunities are firmed: develop budgets and work plans for approval and execution; prepare quarterly forecasts for its immunisation expenditures by budget-line, including a budget verses expenditure variance analysis; and provide these reports to Gavi, along with information on the net unspent and uncommitted cash position.
- For all future Gavi-disbursements, prepare a detailed forecast cash flows. This forecast should be synchronised with the matching expenditures planned for the period.
- Discuss and document risk mitigation measures with Gavi, so as to clarify how the Ministry will identify, and address a possibility of any future under spending of Gavi-provided funds.

Management response in Annex 5: Management Comments and Action Plan

5.2 Vaccine and supply chain management

In Indonesia, the central government is responsible for policy, standard setting and allocating funds to the subnational level made up of 34 provinces, which have their own local governments and are responsible for implementing programmes. Thus, the provision of health services in Indonesia is fully decentralised. Immunisation services are typically provided by village health posts (posyandus), maternity clinics (polindes), and health centres (puskesmas).

In addition to being the MOH's principal vaccine supplier, Bio Farma also provided logistical support, both by providing and running the country's central vaccine store as well as by delivering vaccines to each respective Provincial Health Offices (PHOs). Bio Farma also acted as a procurement agent for the GOI for the vaccines that it did not manufacture itself. At the provinces, the PHOs were responsible for vaccine warehousing, distribution and forwarding to the Districts.

At the central level the DGDPC was responsible for managing the MOH's relationship with Bio Farma. Thus, at the start of each year the DGDPC provides Bio Farma with an annual allocation of vaccines to provide to each province, based on respective estimated birth cohorts.

As part of its general review and understanding of the cold chain, the Audit Team visited Bio Farma, as well as a sample of three sites based in the three Provinces, namely: Jawa Barat, Jawa Timur and Sumatera Barat.

5.2.1 Weaknesses in vaccine handling & recording

The Audit Team reviewed select subnational vaccine management practices for both provinces visited, Jawa Timur and Sumatera Barat, as well as the corresponding oversight thereon by the central MOH Level. The following weaknesses were identified at the central level:

- The MOH units such as DGDPC did not undertake sufficient supervisory visits to the provinces and districts, especially those that with suboptimal programme performance. This issue was also highlighted by the External Auditors in 2015. However, to date the auditors' recommendation was not satisfactorily addressed;
- There was no overall view or report on the overall consolidated vaccine stock levels, such as potential/real 'stock outs';

Similarly, at the provincial level:

- In Jawa Timur provincial store, the manual vaccine records were not updated on a timely basis.
- In Sumatera Barat provincial store, there was no evidence of compliance with the Earliest Expiry First Out (EEFO) principle; the provincial store's stock records did not keep track of pertinent and necessary information on the vaccines, including details on the Vaccine Vial Monitors, expiry dates and batch numbers.

Cause

The DGDPC at the central level did not undertake regular supervisor visits to the provinces to review vaccine handling and recording practices. Also, the DGDPC did not have a stock management tool that gave visibility of vaccine stock levels at the provinces.

Risk/Effect

Without reliable stock records being on file, the warehouse managers' ability to identify, manage and keep track of vaccines throughout the supply chain might be compromised. Unreliable or incomplete data on the status of stock holdings can result in some vaccines being stocked out or wasted, and compliance with EEFO requirements cannot be demonstrated.

Recommendation 4 - Essential

The Ministry of Health recommended to:

- Undertake regular support supervision visits to the sub-national level to ensure that vaccine management practices are operating effectively and in accordance with WHO guidelines.
- Put in place software or a manual tool to collect vaccine records from provinces every month.

Management response in Annex 5: Management Comments and Action Plan

5.2.2 High wastage rates reported for pentavalent vaccines

Since introducing pentavalent vaccine in 2013, the MOH estimated its open vial wastage rate to be 30%. This rate substantially differs from the WHO's 10% indicative vaccine wastage rate for a five-dose vials of pentavalent vaccine. So as to optimally manage vaccine wastage rates, the WHO encourages all countries to record, track and regularly review at all levels of the supply chain. However, currently the MOH does not require any of its vaccine stores and the health facilities to record their vaccine vial wastage, resulting in the country's actual wastage rate not being accurately documented and known.

Senior officers at the MOH justified that many of the target populations live on remote islands and reaching them requires many outreach activities throughout the year. It was also clarified that the higher than expected wastage rate for Pentavalent was partly due to the national policy which requires basic health staff to discard all of their open vials at the end of each day. This contrasts unfavourably with the WHO guidelines which recommends that, subject to specific conditions[11], the opened vial of pentavalent vaccine can be kept and used for up to 28 days after opening.

Although the Audit Team accepts that higher wastage rates may be necessary in more remote areas without adequate cold chain storage, it recognised that this usually would be less applicable for urban areas and therefore should not be generalised across the country. In the absence of up to date credible, validated data on wastage, assumptions on actual the pentavalent usage cannot be substantiated. The MOH plans to undertake a nationwide study of its open vial policy in 2018.

The DGDPC team explained to the Audit Team that until late 2016, the country had prioritised increasing its immunisation coverage by increasing supply, with no consideration or strategy for managing vaccine wastage.

Cause

[11] See detailed summary of WHO's multi-dose vial policy (2014) at http://www.who.int/immunization_standards/vaccine_quality/pq_287_dtphepbhib_10dose_vial_biofarma/en/, accessed 30 November 2017.

The MOH has not established a requirement for the reporting and monitoring of vaccine wastage for open and unopened vials.

Risk/Effect

In absence of the actual wastage data, the MOH cannot identify areas with high wastage rates and is unable to address poor practice, inefficiencies or excessive losses so as to plan, develop and execute suitable interventions to address wastage.

Recommendation 5 - Essential

The Audit Team recognises the MOH's 2018 plan for the study of open vial policy as a useful approach to help clarify the issue of unchecked vaccine wastage. It is therefore recommended that this study be used as an opportunity to establish a comprehensive nationwide policy on recording, monitoring and reporting on open and close vial wastage rates.

Management response in Annex 5: Management Comments and Action Plan

5.2.3 Inadequate fixed assets management of Cold Chain Equipment

The Audit Team's review of the management of the cold chain equipment at Jawa Timur and Sumatra Barat vaccine stores identified the following weaknesses:

- There were no overall consolidated fixed asset register in place identifying the status, type and location of cold chain equipment held by each province; and
- No annual physical verifications of the cold chain equipment was done by the provinces, and no information on the condition of the assets was reported to the central MOH to help track equipment obsolescence and forecast replacement funding.

Cause

Without the provision of a sufficient, reliable and dependable Cold Chain, the carrying capacity and the sustainability of the vaccines dependant thereon cannot be assured. The cold chain equipment were not managed according to the national policy which requires recording of the assets in a register. The MOH did not enforce controls over the management of cold chain equipment procured with Gavi-provided funds.

Risk/Effect

Inadequate checks over the status of cold chain equipment at sub-national level, combined with the lack of annual physical verifications, increases the risk of poorly informed decisions being taken on planning issues such as maintenance, replacement or capital expenditure of additional cold chain units.

Recommendation 6 - Essential

Cold chain equipment management at district level and the corresponding oversight function by the central level thereon, should both be strengthened. Specifically, a consolidated inventory listing identifying the capacity, condition and location of all cold chain equipment at the district-level should be maintained and updated at least annually. Similarly, all districts should perform physical verifications each year immediately prior to reporting information on their cold chain inventory to the central level.

Management response in Annex 5: Management Comments and Action Plan

5.3 Financial management and expenditure control

Aide Memoire, signed between the MOH and Gavi in November 2011, required financial management of Gavi-provided funds in accordance with Indonesia's public financial management regulations.

Gavi grants were managed across four Implementing Units (IU), each IU had a Programme Manager responsible for carrying out the agreed activities in accordance with grant budgets and Annual Work Plans (AWP). Within Indonesia's Public Financial Management system, the Programme Manager is the programme's "Authorised Budget User". The IUs also had a dedicated Programme Management Unit (PMU) with a finance unit responsible for financial control and approval of those payments that are in an approved AWP. There was adequate segregation of duties as demonstrated by the key roles within the finance unit:

- The *Commitment Maker* is an officer carrying out the daily task of verifying planned expenditure against the budget and cost breakdown and provide the administrative authorisation of budget spending.
- The *Assistant Treasurer* is an officer performing treasurer duties within an implementing unit and reporting to the Treasurer of the spending unit.
- The *Treasurer* of a spending unit is an officer responsible for receiving, storing, paying out, administering and accounting for funds.

5.3.1 Absence of an adequate accounting system

One of the fundamental principles for accurate, complete financial books and records is a suitable audit trail or referencing system, which links overall expenditures as reported in the annual financial statements, to individual transactions in the accounting records, and thereon down to the underlying supporting documents.

In order to accurately record financial transactions, books of account are usually maintained using a double-entry system. This system typically requires that as a minimum: expenses are recorded in a journal, cash receipts and payments in a cash book, and all transactions are consolidated in a General Ledger. In order to configure and organise all entries into the general ledger, a hierarchical structure called a chart of accounts, systematically arranges how each financial transaction should be grouped in order to facilitate overall analysis and reporting on the sum of activities. Most off-the-shelve accounting software ensure compliance with the double-entry recording system.

At the central level, the MOH managed its books and records using a governmental budget system, called "Saiba". However, the Audit Team noted that there was no electronic accounting system in place at the programme implementing units, including for the Gavi-supported Programmes. Gavi-funded programmes' financial data was manually recorded, using Microsoft Excel. There was no general ledger in place, meaning that it was not possible to consolidate expenditures from the books of the various IUs and provinces. Also, the expenditures from individual transactions were crudely recorded under activities and budget codes, rather than using a systematic chart of accounts.

In addition, each implementing unit also maintained a manual cashbook in Microsoft Excel for each Gavi specific bank account. The cashbooks contained details on all cash and bank transactions including: cash payments, transfers between bank accounts, and cash advances. At the year end, all IUs (except for the Public Pharmacy unit) manually prepared a Consolidated Summary of Expenditure (CSE), using Microsoft Excel. The CSE illustrated total expenditures incurred for each activity, without showing details of individual transactions even when the activity involved several payments. In the

absence of details for individual transaction, either in the CSE or cash book, the financial information was not easily traceable to supporting documentation.

The Audit Team reviewed the underlying manual books and records and noted that the preparation of the CSE was an onerous and manual task as the transactions were not grouped in accordance to a chart of accounts, and no consolidated financial records were maintained.

Also, the MOH did not have any back-up policies in place to safeguard and minimise the risk of losing or corrupting its electronic data, including its primary accounting records. Moreover, access to these records maintained on Excel was not restricted. There were no IT servers in use on which documents could be saved and shared across the IUs' staff. Instead, documents were saved independently on each staff member's computer. Finally, there were no formal procedures in place managing the transfer of primary records and data when staff were terminated or left.

Cause

Gavi-provided funds were recorded using manual books and records, which lacked appropriate controls. No adequate systems were in place to safeguard key electronic data.

Risk/Effect

The MOH's accounting books and records did not provide detailed and timely reports; and there was no proper audit trail from the underlying records. Manually maintaining accounting records is prone to errors and risks Excel spreadsheets being lost or data being corrupted.

Recommendation 7 - Critical

The MOH is recommended to:

- Improve its accounting system to demonstrate a clear audit trail, such that its books and records are all correctly referenced to the supporting documentation, and during the preparation of the financial statements that these are clearly referenced to the underlying records;
- Consider automating its books of accounts, by introducing a suitable accounting system, in order to produce detailed reports, as well as to increase the accuracy of its primary accounting records; and
- Carry out regular backups of its data to a server to decrease the risk of data loss. Formal procedures should also be enforced to ensure that the programme related files and information is transferred by staff leaving the programme.

Management response in Annex 5: Management Comments and Action Plan

5.3.2 Lack of budgetary management and control

For each Gavi grant, the Directorate General for Disease Prevention and Control (DGDPC) prepared an Annual Work Plan (AWP), providing details of approved activities to be implemented during the upcoming year. However, the Audit Team noted several weaknesses with regards to the budgeting and expenditure monitoring procedures:

- AWPs were prepared before the start of the year to assess the level of funding required and to be included in the MOH's overall budget. Thereafter, the AWPs remained as drafts and were only finalised retroactively at the end of the year, based on the specific activities completed

during the year. Given this approach, the total expenditure reflected in the end of year report always matched the finalised budget, detracting from the AWP's value of assessing the programme's performance. There was no documentation on file justifying the basis and reasons for changes between the draft and the finalised year-end AWPs;

- A single AWP was prepared for each Gavi grant. All of the Gavi-supported activities were implemented across at least two IUs, but an IU-specific plans and budgets were not prepared. As a consequence, none of the IUs could effectively undertake budget and costs monitoring of their respective activities, resulting in each unit not being able to effectively assess their performance against the AWP; and
- At year end, a report of the consolidated expenditures were tied back to each Annual Work Plan format, illustrating the actual cost compared to the overall approved AWP activity and budget. However, due to the disaggregated nature of expenditures across the IUs it is questionable to what extent there was any value in these consolidated records. There was no evidence on file of the consolidated records ever being monitored by MOH management. The consolidated records were also effectively unexploited, as no variances analysis were prepared for the MOH to take action.

Moreover, when reviewing the DGDPC's expenditures of Gavi provided funds, the Audit Team noted that many activities which had been budgeted for were not implemented and this was reflected in the low rate of fund-utilisation. There was no documentation or approval on file that justified non-implementation or delay.

Cause

Insufficient procedures, controls and guidance establishing the basis and modalities for how AWPs should help direct, manage and control the programmes.

Risk/Effect

Results cannot be properly assessed where there is no credible process in place to monitor progress against target indicators for the Gavi supported programme. It is not possible to pro-actively monitor that activities are implemented in accordance to the approved AWPs and budgets, and to ensure that performance is in line with the programme's objectives.

Recommendation 8 - Critical

- A more comprehensive version of the programmatic AWPs should be prepared, which includes both financial and programmatic indicators, in order to assess programmes' performance.
- In addition, implementing unit-specific budgets should be prepared so as to allow each of them to monitor their performance against their agreed activities and objectives.
- Staff at the Gavi-supported PMU should perform analysis of expenditure in comparison with budgets and provide reports to DGDPC for management action.

Management response in Annex 5: Management Comments and Action Plan

5.3.3 Ineffective monitoring and supervision by DGDPC of programme and financial performance

Central level

The Audit Team's review of the DGDPC's supporting documents for those national level activities which it directly executed, revealed weaknesses in the quality of monitoring and supervision activities undertaken by its staff.

Attendance list were not pre-approved – The relevancy of the attendants and speakers to the trainings/ meetings could not be verified because prior to the event, their selection was not subject to any pre-approval by an appropriate authority. Verifying trainers and participants ensures that only the target group participate in the trainings and receive allowances. Though the names of participants were reflected in the payment records, there was no documentation on file justifying the selection, the relevance of the event to their professional role, information on expected deliverables and evidence that they attended and participated.

According to the MOH, heads of the invited entities decided the attendees. Except when the participants were invited by names, the meeting committee was in no position to reject them.

Missing reports on the activities undertaken – The Audit Team noted that for more than half of the training and meeting events it reviewed, no report on the activity was prepared.

No consolidated list of Gavi supported programme staff – The Gavi supported PMU at DGDPC did not maintain an accurate and complete summary of all of its staff/consultants who received regular monthly allowances from Gavi-funds. Instead such information was scattered and not updated, and key information including staff turnover and vacant posts was not available.

Provincial level

At the beginning of the year, the central-level DGDPC unit disbursed Gavi-provided funds to each of the 23 Provincial Health Offices (PHOs) based on their respective AWP and budget. The funds were transferred as a single amount so as to cover their respective expected annual expenditure.

The following shortcomings were observed in the controls and procedures in place:

- The DGDPC treasurer recorded the total amount transferred to all PHOs as a single transaction in the cash book, without keeping a list of amounts per PHO.
- The DGDPC did not have any system in place to track and monitor how each PHO reported on the use of the funds advanced. Also, the DGDPC was not able to intervene to address poor financial performance;
- The PHOs were meant to submit a monthly financial report to DGDPC on these funds. In practice, the PHOs only submitted an annual summary of their expenditures. As a result, the central level was unable to track and monitor overall consolidated expenditures, during the course of the year;
- At year end, the DGDPC Treasurer recorded the consolidated expenditure figure for each PHOs in the cash book. However, there was insufficient detail on file to link the transfers and related liquidations as cash book records were maintained by programme, and not by province;
- The Audit Team noted that the central DGDPC implementing unit did not perform due diligence or perform checks on the PHOs' summaries of expenditure. This, because the DGDPC's staff were unable to validate the completeness and accuracy of their submissions as they did not have access to the provinces' underlying supporting documentation which were kept at the provincial level.

Cause

Central level

- Absence of an independent review/ approval to ensure that the choice of participants and speakers for trainings/meetings, was based upon the event's relevancy to their roles, and that the selection of individuals was done in a transparent manner.
- Incomplete supporting documents kept on file for training/events (e.g. participation register, activity reports, etc.) on file; and
- A lack of guidance requiring that appropriate human resource records be maintained for all individuals receiving remuneration from the Gavi provided funds.

Provincial level

- The MOH did not set-up a suitable system to track and manage the funds advanced to PHOs, in the absence of which PHO expenditures were not properly recorded and reported. The Gavi-provided funds disbursed to the subnational level were not subject to the appropriate financial monitoring, and or to various other requirements provided for within the national financial system.

Risk/Effect

Central level

A non-transparent selection process may lead to inappropriate events or participants being convoked. Proper records need to be maintained to ensure that only eligible participants, staff or consultants duly receive appropriate allowances and entitlements.

Provincial level

In absence of an adequate financial monitoring and supervision; there is a risk that the funds may be used for unintended activities.

Recommendation 9 – Essential – Central level

The MOH is recommended to ensure that:

- Prior to the meeting, the invited institutions provide a list of participants justifying the selection criteria. The list should be preapproved by the implementing unit organising the meeting.
- For each event, an activity report should be prepared and filed with the other supporting documents, shortly after the activity is completed.
- A comprehensive list of all staff and consultants duly receiving salaries, from the Gavi-supported programmes is maintained.

Management response in Annex 5: Management Comments and Action Plan

Recommendation 10 – Essential – Provincial level

The MOH is recommended to put in place a system to track and manage its advances to PHOs. Each transfer to PHOs should be recorded in an advance ledger as well as in the DGDPC's cash book and general ledger. All subsequent liquidations by the PHOs should be monitored. The PHOs should submit monthly financial records to the DGDPC and the DGDPC should perform spot checks on the expenditure reported, to minimize the risk of involuntary errors or misuse.

Management response in Annex 5: Management Comments and Action Plan

5.3.4 Unreconciled financial records

The 2011 Aide Memoir required preparation of annual grant specific financial statements and to have them audited by the external audit by the Auditor General of the Government of the Republic of Indonesia.

The Audit Team performed a comparative analysis between the financial statements and the financial records and noted the following exceptions:

- The total expenditure reported in the MOH's financial statements for the years 2014-2016 did not reconcile with the MOH's accounting records, i.e., consolidate statement of expenditures. The MOH was not able to justify the unreconciled figures. The total unreconciled difference was IDR 608,804,515 (USD 72,121), the expenditure in the financial statement was higher.
- Furthermore, an unreconciled difference of IDR 40,069,177 (USD 2,982) was noted between the consolidated closing cash and bank balance stated in the unaudited financial statements for 2016 and balances per the cashbooks maintained at the IUs. The cash balance in the financial statement was higher.

It is likely that the expenditures and cash balances reported in the financial statements were adjusted in preparation for or in response to the external audit; or for any other legitimate reason. However, there was no evidence of what such adjustments, if any, were. According to the MOH, the responsible accountants were no longer employed with the MOH and therefore retrieving the information was difficult. The accounting records were maintained on individual computers and there was no proper handover of the programme data when the responsible accountants left the MOH.

Given that the financial statements were audited by the Auditor General of Indonesia which had not qualified or raised this particular issue, the Audit Team could place reliance on the external audit.

Cause

The MOH's did not have an adequate process and systems in place to demonstrate how it prepared its financial statements from its underlying books and records, including maintaining a proper audit trail for the preparation of its financial statements.

Risk/Effect

Inaccurate or erroneous financial reporting and loss of financial data and misappropriation of assets.

Recommendation 11 - Essential

The MOH finance department is recommended to put in place a computerised accounting software for Gavi-provided funds. The accounting staff at the Gavi-supported PMU should reconcile the books of accounts, including: ledgers and cashbooks at the end of every month, quarter and year. The MOH finance department should review the books of accounts every month, quarter and year for completeness and accuracy.

Management response in Annex 5: Management Comments and Action Plan

5.3.5 Weak cash and bank management controls

5.3.5.1 Excessive use of cash

Excluding the payment for the self-procurement of the vaccine and immunisation supplies, the majority of the programme expenditure, were paid in cash.

On a regular basis, the Treasurer withdrew cash from a Gavi-grant designated bank account for approved activity based on the duly approved payment documents. According to best practice, cash payments should be limited to few and small payments. However, payments exceeding an approximate range of IDR 3 – 4 million (USD 200 - 300), including key activities such as meetings or workshops, did not appear justified, particularly when the cash was paid directly to a MOH staff member in charge of an activity, or to a supplier.

From discussions with the MOH central-management staff, the Audit Team noted that some of the programme staff were frequently required to travel to various provinces with cash amounts larger than IDR 30 million (USD 2,000) so as to effect payments locally.

Cause

The MOH did not appear to have suitable policies in place to limit the magnitude of cash payments, and to clarify both responsibilities and the liabilities associated when carrying cash for the programmes. According to the MOH, Indonesia is gradually transitioning toward non-cash transaction. The MOH is aware of the risk of large cash payments. However, for practical reason the cash basis is still in practice.

Risk/Effect

Cash-based transactions are not as traceable as cheques or bank transfers, and thus possesses several risks including, loss and misappropriation. Cash transactions are also harder to trace and verify for audit purposes.

Recommendation 12 - Essential

Whenever possible and especially for larger payments, more secure methods of payments, such as the use of cheques and bank transfers, should be used so as to reduce the possibility of mistakes or misappropriation.

Management response in Annex 5: Management Comments and Action Plan

5.3.5.2 Poor controls over advance payments

Each central-level Programme staff responsible for the implementation of assigned activities in accordance to the IU's respective AWP, obtained approval from their line manager. Thereafter, they forwarded the approved request for a cash advance to the IU's Treasurer for execution. Each request identified the corresponding lump-sum amount required, in accordance with the approved annual budget. On receipt of the cash from the Treasurer, the staff undertook the agreed activities and subsequently submitted supporting documentation to close out the advance.

Insufficient controls over staff advances in cash

There were no procedures by which outstanding advances are monitored and formally liquidated. The IUs did not maintain records confirming cash receipts by their staff. In cases where staff received money on behalf of other staff, there was no record of the intended beneficiaries. When the advanced funds were surplus to needs, the unspent cash was retained by the staff for future activities, rather than depositing the funds back into a Treasurer-managed bank account. However, there was no guideline or documentation in place, describing the process for how to manage and account for unliquidated balances. Furthermore, no accounting deadlines were established as to when staff advances should be liquidated once the activities were completed, so as to ensure that the advances and expenditures associated were promptly closed out.

Cash payments not properly recorded nor reconciled regularly

No credible accounting transaction was recorded at the time that advances were paid out in a manner that would enable tracking accountability after the Programme person completed the activity. For instance, the Gavi-supported PMU finance team did not use cash payment vouchers to record the payments. The only cash payments for which evidence is retained relate to the distribution of per diems, for which recipient lists are signed. Good practice would require that at the time monies are paid out to staff, key accounting information is recorded and placed on file, including: transaction reference, date, amount, purpose of payment, payee, and the relevant approvals. Likewise, each time an advance is released, a written record be retained for all of the remaining outstanding advances not yet liquidated by the staff concerned. For example, this information should also probably be written on the cash payment voucher for control purposes.

The IU Treasurers did not perform any bank reconciliations between the cashbook, the bank account and the remaining advance amounts still held by the various programme staff.

Cause

There were no suitable policies in place governing how at the central level how the programmes' cash and treasury should be managed, including guidance on what suitable templates and primary accounting documents should be used and placed on file.

Risk/Effect

Poor cash management increases the risk of irregular activities and the potential for individuals to misuse programme funds. In the absence of strict deadlines for when advances should be liquidated, to ensure that the advances and associated expenditures were promptly accounted for and closed.

Recommendation 13 – Essential

The MOH is recommended to put in place clear policies and procedures to ensure sound cash management and the traceability of cash movements. Specifically, the Treasurer should:

- Only provide cash advances to staff after they have fully liquidated all of their prior advances.
- Monitor the aging of all cash advances to programme staff;
- Monthly reconcile the cash payment records to the accounting records.
- Monthly reconcile the cash book, the bank account and the outstanding physical cash; and
- Ensure that a senior MOH finance official regularly reviews and signs off against the books of accounts, records and reconciliations related to lump sum, cash and advance payments.

Management response in Annex 5: Management Comments and Action Plan

5.3.6 Expenditures questioned by the Audit Team

5.3.6.1 Questioned expenditures – Central level

The Partnership Framework Agreement Section 20 (c) states, that "the government shall ensure that all expenses relating to the use or application of funds are properly evidenced with supporting documentation sufficient to permit Gavi to verify such expenses".

The Audit Team noted that there was no proper filing or archiving system in place both at central and sub-national levels, making it difficult for the programme staff in the IUs and provinces visited to locate and retrieve documents. In addition, the financial documents were not cross-referenced to the ledgers making it onerous to trace the supporting documents both to and from the accounting records as well as to ascertain completeness of documentation. None of expenditure invoices were stamped 'PAID' as required and assigned a Gavi project code, increasing the risk of an invoice being used to evidence multiple payments. Moreover, the financial reports provided for the audit differ in amount from the expenditure reports provided to the Ministry of Health Inspectorate General for their subsequent review. Differences were noted for two directorates as follows;

Table 6a: Differences between financial reports and expenditure documents for Directorate of Health Promotion

Year	Total expenditure per financial report provided for audit	Expenditure from documents provided for review	Difference	Difference USD	Remarks
2014	2,945,260,048	2,148,598,886	796,661,162	67,065	IA-MoH could not verify the expenditure with the respective supporting documents
2015	3,790,000	3,790,000	-	-	
2016	-	-	-	-	
Total	**2,949,050,048**	**2,152,388,886**	**796,661,162**	**67,065**	

Table 7b: Differences between financial reports and expenditure documents for Directorate of Public Health

Year	Total expenditure per financial report provided for audit	Expenditure from documents provided for review	Differences	Difference USD	Remarks
2014	521,911,050	528,740,450	-6,829,400	-575	IA-MoH was not able to assess the real expenditure for each activity
2015	1,143,930,612	1,139,539,119	4,391,493	328	
2016	7,081,804,967	7,416,715,277	-334,910,310	-25,168	
Total	**8,747,646,629**	**9,084,994,846**	**-337,348,217**	**-25,415**	

The above questioned amounts also include accountabilities reviewed by the Ministry of Health Inspectorate General during 2018.

For the expenditures reported by the DGDPC unit, supporting documentation for expenditures incurred at the subnational level were retained only at the provinces. In absence of underlying provincial supporting documentation, the DGDPC was unable to verify or validate any of the CSEs they received from the provinces. The questioned expenditure is as below.

Table 8: Breakdown of questioned expenditures by implementing unit

Entity	Ineligible	Unsupported	Irregular	Total Amount IDR	Total Amount USD
EPI	8,400,000	127,446,960	260,000	**136,106,960**	**10,933**
Public Health	-	243,451,732	-	**243,451,732**	**18,293**
Health Promotion	-	458,454,272	-	**458,454,272**	**38,558**
Total	**8,400,000**	**829,352,964**	**260,000**	**838,012,964**	**67,784**

Cause

Inadequate procedures and controls for filing, retention and reconciliation of primary accounting records.

Risk/Effect

Weaknesses in record keeping and filing prevent verification of reported expenditure. Also, in the absence of proper accounting and record keeping, the MOH does not have in place safeguards to ensure that donor funds are used for the purpose intended, or in accordance with the agreed Partnership Framework Agreement.

Recommendation 14 - Essential

The Implementing Units should file all programme documentation at the unit level in a methodological filing system. All supporting accounting documents should be appropriately referenced to ensure that they can be promptly identified if needed, including a suitable audit trail so that these documents can also be reconciled to the overlaying accounting books.

Management response in Annex 5: Management Comments and Action Plan

5.3.6.2 Questioned expenditures– Province level

The Audit Team selected PHOs in Surabaya (Jawa Timur) and Padang (Sumatera Barat) and found that the primary financial records were poorly filed, and that there was an inadequate audit trail between the books of accounts and the underlying documentation, viz.:

- Audit trail: the PHOs did not complete books and records with clear cross-referencing, resulting in it being an onerous procedure to trace transactions down to the underlying supporting documents.
- Staffing: The staff responsible for financial management did not have sufficient financial skills or had not been trained for specific donor reporting requirements such as Gavi. As a result, the accounts staff at PHOs did not maintain proper accounting records, nor could they provide explanations for the financial management procedures they followed.
- Cash advances: The PHOs did not submit liquidations for advances received and this resulted in delay in recording of expenditure at the central level.

  At the two provinces, a total of IDR 8,903,401,652 (USD 690,195) was reviewed, i.e., 30% of the expenditure reported by the two provinces during the audit scope period.

Table 9: Breakdown of questioned expenditures by Province

Entity	Ineligible	Unsupported	Irregular	Total Amount IDR	Total Amount USD
East Java	3,570,000	550,000	2,840,000	**6,960,000**	**529**
West Sumatra	29,600,000	5,694,000	1,300,000	**36,594,000**	**2,747**
Total	**33,170,000**	**6,244,000**	**4,140,000**	**43,554,000**	**3,276**

Cause

Complete and appropriate PHO books and records, including adequate supporting documentation were not maintained in a format, which allowed for transactions to be promptly matched to the overall books and ledgers. Weak oversight and monitoring by the central level MOH exacerbated poor accounting behaviour at the PHO level.

Risk/Effect

Where the PHO-level accounting systems are not accurate, the financial information they report to the central-level MOH may not be reliable.

Recommendation 15 – Essential

- The MOH is recommended to guide the PHOs on what is considered as necessary and complete supporting documentation for donor-funded activities.
- The MOH is recommended to ensure that all PHOs maintain adequate accounting books and records, including a suitable and systematic filing system for all supporting documents. These documents should be appropriately referenced so that they can be promptly located and reconciled to the overall accounting books and ledgers.
- During the PHO spot checks, the MOH central level staff should ensure that the PHO's expenditures are supported by adequate documentation.

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5.4 In-country oversight mechanisms

Introduction

Gavi's Transparency and Accountability policy requires that Gavi-funds at country level are managed in a transparent and accountable manner, through adequate in-country oversight mechanisms. Within this context, the Audit Team reviewed the effectiveness of assurance provided by the External Audit, the Internal Audit and the Inter-agency Coordinating Committee (ICC).

Health Sector Coordinating Committee (HSCC)

In the Indonesian context, in the Inter-Agency Coordination Committee for Immunisation (ICC) merged with the Health Sector Coordination Committee (HSCC), under the Chair of the Secretary General of the MOH. During the period 2014-2016 the Health Sector Coordinating Committee met three times each year. This Committee was represented by the Ministry of Health as well as by several Gavi Alliance partners including the World Health Organisation (WHO), UNICEF, AIP HSS and CDC. The Ministry of Health representatives included the Directorate General of Disease Control and Environmental Health, the Directorate General of Nutrition and MCH, the Directorate General for Health Promotion, the Directorate General of Pharmaceuticals and Medical Devices and the Centre of Technical Cooperation. The HSCC actively discussed and documented the programmes' activities, progress and challenges throughout this three-year period.

External Audit

The Auditor General for the Government of the Republic of Indonesia undertook external audits of the Gavi-specific Programme Financial Statements for the financial years 2014 and 2015, in line with National Regulations and the Gavi Partnership Framework Agreement. The Audit Team reviewed the how proactive and responsive was the MOH in following up and implementing the Auditor General's findings and recommendations accompanying the 2014 and 2015 audit reports. A number of shortcomings in this follow-up process were noted as explained further in ***section 5.4.1.***

As at 10 November 2017, although the 2016 Financial Statements for the programme were prepared and presented to the Auditor General, the auditors have not yet completed their external audit and the resultant audited financial statements are not yet finalised.

Internal Audit

The Gavi-funded programmes were outside of the scope of Internal Audit of the Ministry of Health. Therefore, no internal audits were performed on the Gavi-supported Programme in Indonesia during the 2014 to 2016 period.

Other Oversight Mechanisms

In addition, a functioning Immunisation Technical Advisory Group (ITAGI) and a National Regulatory Authority (NRA) were in place.

5.4.1 Unsatisfactory mechanism to follow up implement audit recommendations

The external audit reports for 2014 and 2015 concluded that due to limitations in the MOH's internal control system, the Gavi-supported programmes might not be able to prevent or detect misstatements in financial reports, nor deviations to the existing regulations. The Auditor General observed that the Directorate General of Disease Control and Environmental Health as Project Manager had failed to sufficiently design and implement suitable internal controls for: (i) its financial

report(s); (ii) its project implementation; and (iii) its compliance with the existing rules and regulations.

The Audit Team reviewed the degree to which the MOH had followed up and implemented the external audit findings and recommendations for both 2014 and 2015. In addition, as at November 2017 the status of audit recommendation implementation indicated that 40% of the issues were not yet implemented and another 20% were only partially implemented.

Table 10: Implementation status of external audit recommendations by the MOH

Implementation status of external audit recommendations by the MOH	
Implemented	4
Partially implemented	2
Not implemented	4
Total	**10**
Note: one issue was considered to be no longer relevant, as it was superseded by events.	

Gavi programme audit largely identified similar control weaknesses and areas for improvement, as those already identified by the Auditor General during their 2015 and 2016 external audits. Issues included:

- Missing/incomplete supporting documentation;
- Reconciliation differences between Financial Statements and accounting records;
- Weaknesses in Monitoring and Evaluation including as represented at the Subnational Level;
- Weaknesses in vaccine and asset management at Subnational Level; and
- Excessive Gavi funds balances being effectively dormant, and subnational cash advances not being returned to the Treasurer.

Cause

The MOH did not delegate to specific officers the resolution and implementation of the external audit findings, which resulted in diluting responsibility and the required actions not being prioritised.

Risk/Effect

Weak internal controls can compromise the MOH's ability to promptly detect and remediate risks of funds being misused.

Recommendation 16 – Essential

The MOH is recommended to formalise and clearly define responsibilities for its process of following up the implementation of external audit recommendations. Specifically, this should include:

- Preparation of a comprehensive action plan to implement the audit recommendations within pre-defined timelines;
- Tracking the progress and regular monitoring to ensure that recommendations are implemented within the agreed time period.

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5.4.2 Gavi supported activities outside of the scope of the MOH Internal Audit

The 2011 Aide Memoir required that Gavi-funds to be on 'budget', and stated that, "Bringing Gavi funds 'on budget' will ensure that they are within the purview and scope of the Inspector General of

Internal Audit of the MOH and, where relevant, the BPKP. The Secretariat of Integrated Immunization Program of MOH[12] shall ensure that the Inspector General of the MOH includes the GAVI funds in the 2010 (and subsequent audit plans covering the duration of Gavi support to the GOI) Action Plan for internal audit". However, the Audit Team observed that in practice, Gavi-support was not included in the scope of the MOH's Internal Audit (IA) function and therefore the IA had not performed audit of the Gavi-supported programmes.

According to the MOH representatives, grants provided by Gavi were earmarked for a particular line ministry, i.e. the MOH, and hence categorised as a direct grant. The direct grants were excluded from a review by the Internal Audit unless there was a specific request from the line ministry.

Cause

The Gavi-supported Programme was considered outside of the MOH's IA scope, because the MOH did formally request that it be included in annual internal audit plans and, this resulted in the Gavi-supported programmes not effectively benefiting from this function.

Risk/Effect

In the absence of the Gavi-supported programmes being exposed to IA's activities, the programmes may not succeed in putting in place effective mechanisms to identify and control their risks. A lack of, regular IA oversight could therefore compromise the MOH's ability to identify underlying control weaknesses and detect any potential misuse of funds.

Recommendation 17 – Essential

The MOH is recommended to expand the scope of its IA function by jointly developing an annual plan for internal audit engagement vis-à-vis Gavi-funded programmes.

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[12] According to the MOH this action requires official powers for implementation and therefore it should be the responsibility of the Directorate General of Diseases Prevention and Control as Gavi Project Manager.

Annex 1: Definitions of audit ratings and prioritisations

A. Audit ratings

The Gavi-supported Programme Audit Team's assessment is limited to the specific audit areas under the purview and control of the primary implementing partner administrating and directing the programme of immunisation. The three audit ratings are as follows:

- **Satisfactory –** Internal controls and risk management practices were adequately established and functioning well. No high-risk areas were identified. Overall, the entity's objectives are likely to be achieved.
- **Partially Satisfactory –** Internal controls and risk management practices were generally established and functioning but needed improvement. One or more high- and medium-risk areas were identified that may impact on the achievement of the entity's objectives.
- **Unsatisfactory –** Internal controls and risk management practices were either not established or not functioning well. The majority of issues identified were high risk. Hence, the overall entity's objectives are not likely to be achieved.

B. Prioritization of recommendations

The prioritisation of the recommendations included in this report includes proposed deadlines for completion as discussed with the Ministry of Health, and an indication of how soon the recommendation should implemented. The urgency and priority for addressing recommendations is rated using the following three-point scale, as follows: Critical – Essential – Desirable

Annex 2: Classification of expenditures questioned by Audit

Adequately supported

Expenditures validated on the basis of convincing evidence (evidence, which is sufficient, adequate, relevant and reliable) obtained by the auditors during the carrying out of their mission on the ground.

Inadequately supported

Expenditure related to activities for which documentation was provided. However, documentation was incomplete as the costs per documents on files did not cover the entire expenditure reported for those activities on the CSE.

Unsupported expenditure

Expenditure for which no documentation could be provided in respect of the entire costs reported for an activity. The documents could either not be located by the programme team during the audit fieldwork or could not be submitted to the Audit Team as not suitably arranged for audit verifications.

Ineligible expenditures

Expenditure which does not comply with the country's programme/grant proposal approved by Gavi or with the intended purpose and relevant approved work plans and budgets.

One or more of the essential items of documentary evidence required by the country's regulations on procurement are missing such as procurement plan, tender committee review, request for quotation, invoice, contract, purchase order, delivery note for goods and equipment, pro-forma invoice, the final invoice, etc.

It also includes expenditure where essential documentation justifying the payment is missing, such as travel authorisation, lack of a technical report or activity report showing completion of the task, signed list by participants.

Annex 3: Audit procedures and reporting

Audit procedures

Using risk-based audit procedures, the audit included an analysis of reported expenditure (in the Annual Progress Reports or any other periodical financial reports), inquiry/ discussions, computation, accuracy checks, reconciliation and inspection of records/ accounting documents and the physical inspection of assets purchased and works performed using grant funds.

The procedures included:

- Review of the Financial Management arrangements for the programmes, focusing on the control procedures e.g. appropriation and approval, segregation of duties, roles and responsibilities, reconciliation, verification of delivery of goods and services, invoice verification, payroll controls, retirement of advances controls and imprest;
- Review of the arrangements for managing the bank accounts, including tracing all withdrawals and transfers from the programme and designated accounts to determine that they are for eligible expenditures for the programmes;
- Review the bank accounts where interest on designated and Programme accounts balances are credited to ensure that the inflows and outflows are appropriate;
- Verify on a sample basis, procurement undertaken to ensure that the applicable policies and procedures are strictly adhered to and that transparency and value for money is maintained;
- Review the mechanism for channelling cash advances from the MOH to the various budget management centres at the various subnational (regions and provinces) levels, and ensure that there are adequate internal controls in place to timely liquidated such advances;
- Undertake field level visits to Subnational levels to conduct interviews of beneficiaries and Health employees and determine whether principal activities actually took place according to the work plan/ schedule of cash advances;
- Visit to the central and Subnational stores to ensure that appropriate supply chain management procedures are in place. Review stores records to ensure that the receipt and despatch of all items is adequately recorded;
- Perform physical verifications, on a sample basis, to check the actual delivery of goods, works and services purchased as per the source documents;
- Assess adequacy of relevant fixed assets policies and procedures and determine whether an adequate fixed asset register is maintained by the project. Verify existence of programme assets on a sample basis;
- Identify, list and document all expenditures which are not eligible for funding from Gavi-supported programme funds. Take photographs/copies of all material and significant supporting documentation which relates;
- Highlight any specific matter of concern that may impede the achievement of the intended objectives of the grant; and
- Make appropriate recommendations and discuss these with the implementing entities.
- Assess compliance with the conditions and requirements of the relevant grant agreements and Gavi policies, i.e. Partnership Framework Agreement, Aide Memoire, Financial Management Requirements, and Transparency and Accountability Policy.

Reporting

The audit findings were discussed with the senior management team of the MOH on 10 November 2017.

Annex 4: Tables in support of audit findings

Table 11: Breakdown of Gavi total support provided to the MOH from 2014 to 2016 (in USD):

Sub-category	2014	2015	2016	Total
Gavi provided cash for Vaccines				
Inactivated Polio Vaccine (IPV)	-	-	4,165,000	4,165,000
Pentavalent Vaccine (Penta)	20,453,500	13,843,500		34,297,000
Sub-total Cash for Vaccines	**-**	**13,843,500**	**4,165,000**	**18,008,500**
Gavi provided cash funds				
Health system strengthening	-	9,420,500	-	9,420,500
Vaccine Introduction Grant - IPV	3,688,500	-	-	3,688,500
Sub-total Cash	**3,688,500**	**9,420,500**	**-**	**13,109,000**
Grand Total	**24,142,000**	**23,264,000**	**4,165,000**	**51,571,000**

Table 12: Breakdown of total reported Gavi expenditure in IDR and USD from 2014 to 2016 as per the Financial Statements[13]

Programme	2014	2015	2016	Total
Immunisation Services Support (ISS)[14]	132,638,900	-	-	132,638,900
Civil Society Organisations (CSO)[1]	4,185,045,489	-	-	4,185,045,489
Health Systems Strengthening (HSS)	26,259,964,416	23,165,171,456	61,189,880,240	110,615,016,112
New Vaccine Support (NVS) / Vaccine Introduction Grant (VIG)	152,328,663,232	124,737,530,762	123,963,455,427	401,029,649,421
Total – IDR	**182,906,312,037**	**147,902,702,218**	**185,153,335,667**	**515,962,349,922**
Total – USD	**15,396,828**	**11,044,133**	**13,913,562**	**40,354,523**

Table 13: Gavi support to the immunisation programme in Indonesia during the period 2002 – 2017.

			Audit Scope				
Support	**Grant**	**2002 - 2013**	**2014**	**2015**	**2016**	**2017**	**Grand Total**
Cash for vaccines and supplies	HepB mono	4,474,000	-	-	-	-	4,474,000
	IPV	-	-	-	4,165,000	6,647,000	10,812,000
	Penta	10,024,000	20,455,500	13,843,500	-	-	44,323,000
	Measles-Rubella Campaign	-	-	-	-	27,769,500	27,769,500
	Injection Safety Devices - IPV	-	-	-	-	163,500	163,500
		14,498,000	**20,455,500**	**13,843,500**	**4,165,000**	**34,580,000**	**87,542,000**
Cash gra	CSO Type A	100,000	-	-	-	-	100,000

[13] Based on audited financial statement for fiscal year 2014 and 2015; and unaudited financial statement for fiscal year 2016.

[14] Gavi provided USD 12.6m for ISS between 2003 and 2007, and USD 4m for CSOs between 2008 and 2012. Residual balances remaining from these grants at the start of 2014 were spent by the end of in 2014.

			Audit Scope				
Support	**Grant**	**2002 - 2013**	**2014**	**2015**	**2016**	**2017**	**Grand Total**
	CSO Type B	3,900,500	-	-	-	-	3,900,500
	HPV Demo - cash support	-	-	-	-	170,000	170,000
	HSS	15,407,000	-	9,420,500	-	-	24,827,500
	ISS	12,636,000	-	-	-	-	12,636,000
	Vaccine Introduction Grant	3,891,000 (Penta)	3,688,500 (IPV)	-	-	100,000 (JEV)	7,679,500
		35,934,500	**3,688,500**	**9,420,500**	**-**	**270,000**	**49,313,500**
Vaccine support	HepB mono	13,037,000	-	-	-	-	13,037,000
	HPV Demo	-	-	-	-	98,075	98,075
	INS	9,856,844	-	-	-	-	9,856,844
		22,893,844	**-**	**-**	**-**	**98,075**	**22,991,919**
Grand Total		**73,326,344**	**24,144,000**	**23,264,000**	**4,165,000**	**34,948,075**	**159,847,419**

Table 14: Breakdown of catalytic support provided by Gavi to Indonesia between January – September 2017 in USD

Gavi Support Type in 2017	**Amount (in USD)**
Measles Rubella Campaign - Cash for Vaccines	27,769,500
Inactivated Polio Vaccine - Cash for Vaccines	6,647,000
Human Papillomavirus Demo - Cash & Vaccine	268,075
Injection Safety Devices – Cash	163,500
Japanese Encephalitis Vaccine Introduction Grant - Cash	100,000
Total	**34,948,075**

Table 15: Schedule of HSS grant disbursements in US Dollars

Tranche	**Date**	**Amount (in USD)**
1	29 September 2008	7,691,000
2	20 March 2009	270,000
3	03 April 2012	3,723,000
4	20 December 2013	3,723,000
5	28 July 2015	9,420,500
Total disbursed		**24,827,500**

Annex 5: Management Comments and Action Plan

No	Recommendations	Management Comments
1	**Programmatic Achievement** **Insufficient and declining DTP3 coverage** **Recommendation 1 - Critical** In the event of future Gavi support, the MOH working with 'high-risk' districts, should take specific time-bound actions to identify and address bottlenecks to achieving the coverage targets. The actions developed should be included in a multiyear workplan with focus on districts with low coverage and a large number of unimmunised children. Also, the central and sub-national levels should agree regular reporting and monitoring arrangements for the work plans, as well as interactions for remedial actions on missed targets.	We agree with the recommendation on how to improve the immunization coverage. But it is important to note that MoH has developed policy and strategies to improve the coverage, such as: i) Strategy to reduce missed opportunities, ii) strategy of immunization in hard to reach population, iii) country wide of "reach every district" strategy etc. The challenges in the decentralized setting is how to make sub national comply with existing policy. The key driver of this problem lays on the commitment of the government, especially at sub national level.
2	**Programmatic Achievement** **Several primary vaccines have not yet been introduced** **Recommendation 2 - Critical** The MOH is recommended to implement a strategy to introduce some of these new vaccines while taking into consideration: epidemiological concerns; the health benefits; Bio Farma's development and production pipeline; and the commercial viability of alternative sources until local production is established.	The GoI is committed to introduce the new vaccines as indicated in cMYP. However, the implementation of new vaccine should be based on ITAGI recommendation and the financial capacity to ensure availability of vaccine. The main challenge is the high price of the new vaccines. Therefore, currently MoH with the support from National Procurement Agency is seeking the possibility of procuring imported vaccines through UNICEF which is much cheaper than market price.

No	Recommendations	Management Comments
3	**Programmatic Achievement** **Underutilised grants and substantial in-country cash balance** **Recommendation 3 - Essential** The MOH should: • Return unused balances totalling approximately USD 3,488,752 to Gavi for the following support grants which have elapsed: HSS, VIG-Penta. • For: the remaining grant balance with the MOH; the bank interest income; and the unallocated funds, in discussion and agreement with Gavi and the in-country alliance partners, identify suitable investment opportunities in critical areas to improve the immunisation coverage. • Once the investment opportunities are firmed: develop budgets and work plans for approval and execution; prepare quarterly forecasts for its immunisation expenditures by budget-line, including a budget verses expenditure variance analysis; and provide these reports to Gavi, along with information on the net unspent and uncommitted cash position. • For all future- Gavi disbursements prepare a detailed forecast cash flow. This forecast should be properly synchronised with the matching expenditures planned for the period. • Discuss and document suitable risk mitigation measures with Gavi, so as to clarify how the Ministry will identify, and address a possibility of any future under spending of Gavi-provided funds.	There was an agreement with Gavi that MoH could use the unused balances of component HSS, NVS & VIG Penta and interest/other incomes for CESAP. Currently Gavi requested to redesign the CESAP proposal to include the country priorities by considering the JA recommendation. The activities funded by unused grant will be managed by EPI and partners (WHO and UNICEF) in 2018-2019. In addition, the undisbursed VIG MR will be disbursed to partners (WHO and UNICEF) to cover the activities of PEF TCA 2018. EPI still needs supporting grant to strengthen the immunization program. EPI will develop additional proposal to utilize the remaining budget if required. Therefore, MoH would like to request the Gavi Audit to reconsider the recommendation#1. Please also note that the unused balances has been a subject for discussion with the Country Program Manager and partners. MoH agree to accept other recommendation.

No	Recommendations	Management Comments
4	**Vaccine and supply chain management** **Weaknesses in vaccine handling & recording** **Recommendation 4 - Essential** The Ministry of Health should: • Undertake regular support supervision visits to the sub-national level to ensure that vaccine management practices are operating effectively and in accordance with WHO guidelines. • Put in place software or a manual tool to collect vaccine records from provinces every month.	We do agree that there is a need to strengthen the frequency and quality of supervision visits. Please note that we have developed the guidance, standardised form and its SOP for vaccine management. However, we still have a problem in the implementation. Effort will be focused on strengthening the effective supervision.
5	**Vaccine and supply chain management** **High wastage rates reported for pentavalent vaccines** **Recommendation 5 - Essential** The Audit Team recognises the MOH's 2018 plan for the study of open vial policy as a useful approach to help clarify the issue of unchecked vaccine wastage. It is therefore recommended that this study be used as an opportunity to establish a comprehensive nationwide policy on recording, monitoring and reporting on open and close vial wastage rates.	The recommendation is well taken.
6	**Vaccine and supply chain management** **Inadequate fixed asset management of Cold Chain Equipment** **Recommendation 6 - Essential** Cold chain equipment management at district level and the corresponding oversight function by the central level thereon, should both be strengthened. Specifically, a consolidated inventory listing identifying the capacity, condition and location of all cold chain equipment at the district-level should be maintained and updated at least annually. Similarly, all districts should perform physical verifications each year immediately prior to reporting information on their cold chain inventory to the central level.	We agree with this recommendation, and it is in line with the Minister of Health Regulation no. 12/2017 on the Implementation of Immunization Program. The status of cold chain has not been optimal yet as indicated in the result of EVMA 2015. Current policy is to request the district level an updated inventory of cold chain equipment as a prerequisite of the proposal submission on the equipment to National level. In addition, the inventory should be done and recorded routinely.

No	Recommendations	Management Comments
7	**Financial records and reporting** **Absence of an adequate accounting system** **Recommendation 7 - Critical** The MOH should: • Improve its accounting system by including in a clear audit trail, such that its books and records are all correctly referenced to the supporting documentation, and during the preparation of the financial statements that these are clearly referenced to the underlying records; • Consider automating its books of accounts, by introducing a suitable accounting system, in order to produce detailed specific reports, as well as to increase the accuracy of its primary accounting records; and • Carry out regular backups of its data to a server to decrease the risk of data loss. Formal procedures should also be enforced to ensure that the programme related files and information is transferred by staff leaving the programme.	We agree with the recommendation to improve the accounting system. We will strengthen the control of records, accounting books and financial statement, and reconcile between the IU and treasurer. We will seek the possibility of applying the accounting software.
8	**Financial management and expenditure control** **Lack of budgetary management and control** **Recommendation 8 - Critical** • A more comprehensive version of the programmatic AWPs should be prepared, which includes both financial and programmatic indicators, in order to assess programmes' performance. • In addition, implementing unit-specific budgets should be prepared so as to allow each of them to monitor their performance against their agreed activities and objectives. • Staff at the Gavi-supported PMU should perform analysis of expenditure in comparison with budgets and provide reports to DGDPC for management action.	The observation of Auditors was correct. Those practices were, however allowed, but not for the government fund. However, the work plan was not arbitrarily made. We agree on the recommendation that we need to develop more comprehensive AWP which can assess the programs' performance.
9	**Ineffective monitoring and supervision by DGDPC of programme and financial performance – central level** **Recommendation 9 18- Essential** The MOH is recommended to ensure that:	We agree that we need to improve the conduct of meeting and training, especially in managing the records, paying the allowance / per diem and reports making appropriately. However, it is most likely that we will not be able to conduct any selection and preapproval process prior to the meeting.

No	Recommendations	Management Comments
	• Prior to the meeting, the invited institutions provide a list of participants justifying the selection criteria. The list should be preapproved by the implementing unit organising the meeting; • For each event, an activity report should be prepared and put on file with the other supporting documents, shortly after the activity is completed. • A comprehensive list of all staff and consultants duly receiving salaries, from the Gavi- supported programmes is maintained.	
10	**Ineffective monitoring and supervision by DGDPC of programme and financial performance – provincial level** **Recommendation 10 - Essential** The MOH is recommended to put in place a system to track and manage its advances to PHOs. Each transfer to PHOs should be recorded in an advance ledger as well as in the DGDPC's cash book and general ledger. All subsequent liquidations by the PHOs should be monitored. /The PHOs should submit monthly financial records to DGDPC and the DGDPC should perform spot checks on the expenditure reported, to minimize the risk of involuntary errors or misuse.	The Project implementing Manual - that has been developed by MoH - requires PHO to submit financial report monthly, quarterly and yearly. However, it has not been complied. Therefore, we accept the recommendation and follow the project manual properly.

No	Recommendations	Management Comments
11	**Financial records and reporting** **Unreconciled financial records** **Recommendation 11- Essential** The MOH finance department should put in place a computerised accounting software for Gavi-provided funds. The accounting staff at the Gavi-supported PMU should reconcile the books of accounts, including: ledgers and cashbooks at the end of every month, quarter and year. The MOH finance department should review the books of accounts every month, quarter and year for completeness and accuracy.	We agree that we need to strengthen the financial recording and reporting. We will internally discuss with the Bureau of Finance MoH in finding ways to improve the performance of the financial management. We will also discuss the possibility of using the computerised accounting software for managing the Gavi grants.
12	**Weak cash and bank management controls** **Excessive use of cash** **Recommendation 12 - Essential** Whenever possible and especially for larger payments, more secure methods of payments, such as the use of cheques and bank transfers, should be used so as to reduce the possibility of mistakes or misappropriation.	Considering the benefit in minimizing risk and the potential in improving financial management, the recommendation is well taken. However, we should seek the possibility of the acceptance of the finance staff in applying this policy.
13	**Weak cash and bank management controls** **Poor controls over advance payments** **Recommendation 13 – Essential** The MOH is recommended to put in place clear policies and procedures to ensure sound cash management and the traceability of cash movements. Specifically, the Treasurer should: • Only provide cash advances to staff after they have fully liquidated all of their prior advances. • Monitor the aging of all cash advances to programme staff; • Monthly reconcile the cash payment records to the accounting records. • Monthly reconcile the cash book, the bank account and the outstanding physical cash; and • Ensure that a senior MOH finance official regularly reviews and signs off against the books of accounts, records and reconciliations related to lump sum, cash and advance payments.	Recommendation is well taken.
14	E**xpenditures questioned by the Audit Team**	

No	Recommendations	Management Comments
	Questioned expenditures – Central level **Recommendation 14 – Essential** The Implementing Units should file all programme documentation at the unit level in a methodological filing system. All supporting accounting documents should be appropriately referenced to ensure that they can be promptly identified if needed, including a suitable audit trail so that these documents can also be reconciled to the overlaying accounting books.	As a matter of fact, the supervision of this practice has been taken by the EPI. However, we admit that there is a need to improve the quality of the supervision, especially on the financial administration and documentation. We accept the recommendation.
15	**Expenditures questioned by the Audit Team** **Questioned expenditures – Provincial level** **Recommendation 19 – Essential** • The MOH is recommended to guide the PHOs on what is considered as necessary and complete supporting documentation for donor-funded activities. • The MOH is recommended to ensure that all PHOs maintain adequate accounting books and records, including a suitable and systematic filing system for all supporting documents. These documents should be appropriately referenced so that they can be promptly located and reconciled to the overall accounting books and ledgers • During the PHO spot checks, the MOH central level staff should ensure that the PHO's expenditures are supported by adequate documentation.	Recommendation is well taken. However, it is important to note that the guidance has been available, but efforts is still needed to make the implementing units at central level and PHOs comply with the guidance.

No	Recommendations	Management Comments
16	**Unsatisfactory mechanism to follow up and implement external audit recommendations** **Recommendation 20 – Essential** The MOH is recommended to formalise and clearly define responsibilities for its process of following up the implementation of external audit recommendations. Specifically, this should include: • Preparation of a comprehensive action plan to implement the audit recommendations within pre-defined timelines; and • Tracking the progress and regular monitoring to ensure that recommendations are implemented within the agreed time period.	Recommendation is relevant to the regular practice., in ensuring the actions are taken place. Therefore, it is well taken.
17	**Gavi supported activities outside of the scope of the MOH Internal Audit.** **Recommendation 21 – Essential** The MOH is recommended to expand the scope of its IA function by jointly developing an annual plan for internal audit engagement vis-à-vis Gavi-funded programmes.	We agree with the recommendation. DG-DPC will communicate with Inspectorate General for the implementation of Internal Audit of the Gavi Grant.