Application Form for: GAVI Alliance Health System Strengthening (HSS) Applications March 2007

An electronic version of this document is available on the GAVI Alliance website (www.gavialliance.org) and provided on CD. Email submissions are highly recommended, including scanned documents containing the required signatures. Please send the completed application to:

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Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline. Proposals received after that date will not be taken into consideration for that review round. GAVI will not be responsible for delays or non-delivery of proposals by courier services.

All documents and attachments should be in English or French. All required information should be included in this application form. No separate proposal documents will be accepted by the GAVI Secretariat. The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents may be shared with the GAVI Alliance partners, collaborators and the general public.

Please direct all enquiries to:
Dr Craig Burgess (cburgess@gavialliance.org) or representatives of a GAVI partner agency.

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Abbreviations and Acronyms

To the applicant

- *Please ensure that all abbreviations and acronyms presented in the application and supporting documents are included here.*

Abbreviation	Meaning
ADB	Asian Development Bank
ANC	ante natal care
APR	Annual Progress Report
Ausaid	Australian Development Assistance
CARE	Catholic Relief Everywhere
CCM	Country Coordinating Mechanism
CDC-MoH	Directorate General for Communicable Disease Control in the Ministry of Health
CHW	Community Health Worker (in Indonesia, this term is usually applied to kaders, but may include bidan di desa in some contexts)
cMYP	Comprehensive Multi Year Plan
CSO	Civil Society Organization
DG	Director General
DHO	District Health Office
DHS	Demographic and Health Survey
DTP	Diphtheria, Tetanus and Pertussis
EPI	Expanded Programme of Immunization
EU	European Union
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GNI	Gross National Income
GOI	Government of Indonesia
HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
HSS	Health Systems Strengthening
IBI	Indonesian Midwives Association
IDAI	Indonesian Paediatric Association
IEC	Information, Education and Communication
Immpact	Initiative for Maternal Mortality Assessment
JICA	Japanese Institute for Development Cooperation
M & E	Monitoring and Evaluation
MCH	Maternal and Child Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
MPH	Master of Public Health
MPS	Master of Professional Studies
Muslimat NU	Muslim Welfare Organization
NGO	Non-government Organization
PATH	Partnership for Appropriate Technology in Health
PDGI	Indonesian Dental Association
PHO	Provincial Health Office
PKK	Women's Welfare Movement
PKM	
Pramuka	Scout Movement
PRB	Population Reference Bureau
SWOT	Strengths, Weaknesses, Opportunities, Threats
SPP (Surat Perintah Pembayaran)	Payment Order

TWG Technical Working Group TBA Traditional Birth Attendant UN United Nations UNICEF United Nations Children's Fund USAID Unites States Agency for International Development WB World Bank WHO World Health Organization WHO/SEARO The South East Asian Regional Office of WHO

Indonesian expressions used in the text

Askeskin (asuransi kesehatan orang miskin) Health Insurance for the Poor

Bappenas (Badan Perencanaan Pembangunan Nasional) National Planning Board Midwife Village midwife, part salaried, part private practitioner MCH handbook

Bidan

Bidan di desa

Buku KIA

Desa Village Alert village (ie alert to health threats)

Desa siaga

Kader Volunteer (unsalaried) community based health worker

Posyandu (pos pelayanan terpadu) Integrated service post, location of a monthly clinic providing MCH services including immunization

Puskesmas (Pusat Kesehatan Masyarakat) Community Health Centre

Pustu (Puskesmas pembantu) Health Subcentre Renstra (Rencana strategis) Strategic Plan

Executive Summary

To the applicant

- *Please provide a summary of the proposal, including the goal and objectives of the GAVI HSS application, the main strategies/activities to be undertaken, the expected results, the duration of support and total amount of funds requested and the baseline figures and targets for the priority indicators selected.*
- *Please identify who took overall responsibility for preparing the GAVI HSS application, the role and nature of the HSCC (or equivalent), and the stakeholders participating in developing the application.*

The overall goal of the proposal made to GAVI is to improve the health of mothers, infants and children. One of the most cost-effective interventions available to achieve that goal is the systematic application of a schedule of vaccinations at key points in the individual life cycle. Prior to the financial crisis of the late 1990s, Indonesia had attained high levels of routine immunization. Since then, population coverage has been less complete, and epidemics of measles and polio have starkly exposed these failings. Analysis of the underlying causes identified some problems specific to the immunization program itself, but also some problems which are systemic in the sense that they affect all programs. The conventional GAVI support has assisted Indonesia to address issues specific to immunization. The opening of the HSS window offers an opportunity to address some of the systemic issues.

Indonesia has closely followed the GAVI guidelines in establishing appropriate structures for developing the proposal and obtaining the endorsement of a wide range of stakeholders. It has established a Health Sector Coordination Committee with representation from three main constituencies: the Government of Indonesia; international partners; and civil society. The Chair of this committee is the Director of Health and Community Nutrition of the National Planning Board, which connects it to the apex authority for development planning in Indonesia. This Committee has authorized the formulation of a proposal and approved the process, which has been led by a Core Team under the authority of the Head of the Planning Bureau, Ministry of Health. The Core Team has representation from the Directorate of Surveillance, Epidemiology and Immunization located in the Directorate General for Communicable Disease Control, the Directorates of Maternal Health, Child Health and Health Promotion in the Directorate General of Community Health, and the Human Resource Development and Planning Board. At different stages, the Core Team has had assistance from various consultants.

The initial steps towards development of a proposal were in the wrong direction, in that they focused on immunization program issues rather than the broader health systems agenda. When this became apparent, the Core Team itself restructured the proposal, using a logical framework analysis to identify important but susceptible systemic barriers to effective service provision. The Core Team recognised that, in accordance with the guidelines issued by GAVI, the selected interventions would need to be focused, but at the same time, systemic improvements would generate benefits going beyond wider immunization coverage.

It is well recognized that Indonesia's health system suffers from a multiplicity of problems, including the consequences of far-reaching decentralization, chronic under-funding, deficiencies in the quantity, quality and distribution of human resources, and a lack of comprehensive and accurate information. However, given the limitations of budget and time imposed by GAVI, the Core Team took the view that resources would be better applied elsewhere. The key problem identified which was susceptible to tangible improvement within the limited time and budget available was the weakness of community support for outreach services, including immunization, and the mirror

image of weaknesses in management of outreach services by the public provider system. The high levels of immunization coverage attained in the period before the economic crisis were largely attained thanks to the widespread availability of services from the *posyandu* (integrated service post) at which outreach services including immunization, ante natal care, family planning, child growth monitoring and nutrition, and oral rehydration therapy were provided. As a consequence of political changes and financial pressures, in many parts of Indonesia there has been serious erosion of the *posyandu* system. Revival of the *posyandu* was the single most important measure proposed by international partners invited to assess the state of routine immunization.

This analysis is not new. It closely reflects two of the principal thrusts of health policy laid down in the *Renstra* (Ministry of Health Strategic Plan 2004-2009). The first of these is the mobilization and empowerment of the community to live healthy lives, embodied in the concept of *desa siaga* (alert villages). The core structures of desa siaga, a village health post with services provided by a village midwife and a number of "volunteer" community health workers, are closely analogous to the preceding structure of *posyandu* attended by community based *kaders* and visiting health centre staff. The second policy thrust is to improve the accessibility and quality of primary care services.

The Core Team therefore defined four objectives in support of the overall goal of improvement of maternal, infant and child health. These were that the community should be mobilized to understand the fundamentals of healthy living and support the provision of MCH outreach services; that the management of MCH services in the public provider system should be improved; that non-government actors should be enlisted in partnerships to strengthen communities and deliver effective services; and that operational research should be carried out into two of the more intractable problems facing the health system. A set of activities designed to realise each objective was then formulated.

For the objective of community mobilization, a sequence of activities is proposed, beginning with local area assessment and mapping, followed by recruitment and training or retraining of *kaders* (CHWs) as necessary. The *kaders* would be trained in the use of IEC materials, including the *buku KIA* (MCH handbook) which would be distributed to families. The community and religious leaders would be sensitised to health issues, and their support enlisted for village level health improvement measures. Once trained, the *kaders* would be expected to participate in the holding of the monthly *posyandu* clinic, and on a daily basis to disseminate the messages of healthy living.

The complementary objective of strengthening the management of MCH activities at district and sub-district level (corresponding to the *puskesmas* or public health centre) would be addressed by a parallel sequence of situation assessment, followed by a training programme, starting with the preparation of district training teams, which would then carry out training of the *puskesmas* team on a modular basis in a series of management topics including micro planning, supervision, monitoring and evaluation, surveillance and management of community development. Prior to the training activities, it would be necessary to develop management tools and training materials and subsequently to provide some operational cost to support outreach activities. To ensure sustained support for these costs in future, staff from the provincial health office would advocate to local government administrations and politicians the importance of adequate budgetary provision for MCH services.

The third objective of forming partnerships with non-government actors in community health improvement would be furthered by a process of identification of partners (CSOs already active in community mobilization or service delivery), the formulation of joint action plans and the expression of these plans in MOUs which would be implemented using the resources available to each partner. Coordination would be ensured by joint monitoring and evaluation, and periodic consultations between the parties. In addition to the engagement of CSOs, two specific activities aimed at for-profit private providers would be their sensitization to government policies and good MCH practices, and the strengthening of the compact between TBAs, private midwives and the public provider system.

Two of the outstanding health system issues, motivation of the health workforce and contracting of non-government providers, would require immense resources if addressed on a national scale. Nevertheless, it is proposed to gain experience by pilot scale operational research on these two issues. It is envisaged that a university would be contracted to carry out trials of different types of incentive for both *kaders* and professional staff. In Papua, the lack of trained health workers is a binding constraint on health service improvement. It is therefore proposed that a trial be made of a contract with a CSO to provide services using its own management and personnel in a currently under-served area.

From the outset, it was appreciated that it would not be possible to implement these activities on a nationally comprehensive basis. Using multiple criteria, including population at risk, epidemiological indicators, immunization coverage, and the fiscal gap between needs and resources, five provinces were prioritized. These were West Java, Banten, South Sulawesi, Papua and West Papua. Between them, they contain approximately one fifth of the total number of districts, and one fifth of the national population. The first three of these are populous provinces in which immunization coverage has been disappointingly low. Papua and West Papua are low in population, but were selected in response to Presidential Instruction 5/2006 which requires all sectors to give special consideration to Papua, recognising the extreme constraints operating in that region. Because of the extreme shortage of human resources in Papua, the community mobilization effort in those two provinces will be concentrated on the coastal areas, approximately half of the districts concerned, but as noted above Papua will receive special attention in the form of a pilot scheme of contracting NGO providers.

The implementation of these proposals using standard government procedures will require teamwork at each level of the health system. At the centre, there will be a designated Executing Agency handling the flow of funds, several Implementing Agencies coordinated by a Technical Committee chaired by the Bureau of Planning, with oversight of the whole activity provided by the HSCC. At the provincial and district levels, implementation activities will be coordinated by the head of the planning division. At the sub-district level, the entire team concerned with outreach activities will be involved in community mobilization and management training activities.

The total cost of implementing the proposed activities is $24.8 million, a figure derived from the conditions set by GAVI (the size of the birth cohort x $2.5 per year x 2 years, 2008 and 2009). Approximately 40% of the total expenditure will be applied to each of the two main activities of community mobilization and MCH management training, while the overhead for management, monitoring and technical assistance accounts for under 7% of the total. A detailed disbursement plan will be developed once acceptance of the proposal is notified, but the Core Team has already prepared a detailed cost estimate based on identified sub-activities and unit costs which underlies the summary presented in Table 8.1

Section 1: Application Development Process

To the applicant

In this section, please describe the process for developing the GAVI HSS application.

- *Please begin with a description of your Health Sector Coordinating Committee or equivalent (Table 1.1).*

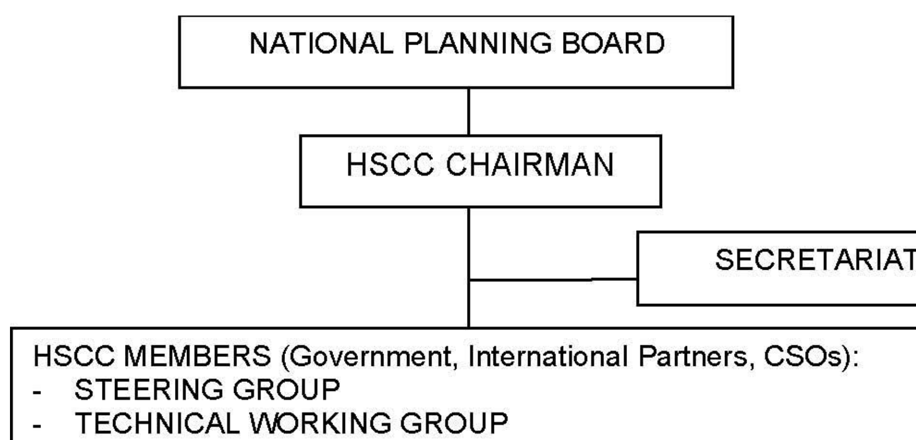
1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

Health Sector Coordinating Committee (HSCC)

HSCC operational since: Previous institutions with a similar structure have existed since at least 1999. In its present form, the HSCC has been actively involved with the development of the HSS Application since August 2007

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



The National Planning Board (Bappenas) is the national apex body within the Government of Indonesia which is responsible for coordinating, guiding and leading national level planning of all development projects including health. In August 2007 the HSCC was re-established in its present form which parallels the CCM for the Global Fund, with a similar composition and purpose. The HSCC has sanctioned the formation of a technical working group specifically to review applications for CSO support and to make recommendations to the HSCC itself. While the HSCC was revived to meet the conditions of the HSS application, it is envisaged by all parties that it will in future provide a forum for a wide range of consultations between government, international partners and civil society on matters of common concern in the health sector. The membership of the HSCC consists of representatives of the Ministry of Health, Ministry of Finance, Ministry of Home Affairs and National Planning Board, international health partners and CSO representatives. At this point the latter are co-opted representatives of the five different types of CSOs recognized by GAVI, but in future it is anticipated that they will develop their own system of choosing their representation. The chairman of the HSCC is Dr Arum Atmawikarta, Director of Health and Community Nutrition at the National Planning Board. The HSCC is not a stand-alone organization, it is structurally attached via its chairman with the Directorate of Community Health and Nutrition in the National Planning Board

Frequency of meetings:[1]

The HSCC has been meeting approximately once per month. There have been five meetings of the HSCC between 20 October 2007 and 29 February 2008, please see minutes attached.

Overall role and function:

It was acknowledged above that the HSCC was developed explicitly to provide the necessary endorsements for the HSS and CSO applications, and to date its meetings have been exclusively devoted to that function, but as also noted it has the potential to meet the long-felt need for a forum in which health issues can be discussed between all interested parties. In particular, it is anticipated that the forthcoming government-led, donor supported Health Sector Review will be planned and monitored by the HSCC

Hitherto, the overall role and function of the HSCC has been to act as a coordination forum for multisectoral bodies to play a directing role during the process of proposal development for GAVI under the HSS grant window. More specific roles will include providing guidance and ensuring multisectoral involvement during the process of project preparation and application for grant, ensure due approval from the Government of Indonesia, submission of application, and at later stage will advise during the implementation phase, and supervise periodic monitoring and evaluation of program implementation.

The HSCC may also appoint a technical task committee (Technical Working Group) to perform any specific task to complement its roles (as and when required). To date, a Technical Working Group has functioned to review CSO proposals and make recommendations to the HSCC.

<u>Terms of Reference of the HSCC</u>

1 Oversee and review preparation of proposals for support to GAVI secretariat as relevant.
2 Periodically monitor, review progress and advice on the policy and strategies relating to EPI in the country in the light of new findings and changing global and regional priorities.
3 Ensure the GAVI-HSS and GAVI-CSO application is in line with the National Health Sector Plan
4 Advise on capacity building and on the implementation of innovation strategies and approaches to Health System Strengthening.
5 Assist in mobilizing internal and external resources from various sources, including GAVI, and ensure proper use of these resources.
6 Promote and facilitate partnership building, including the involvement of NGOs and the civil society in the GAVI-HSS project activities.
7 Endorse and sign the final version of the GAVI- HSS application, and then submits to the Ministry of Health, National Planning Board, and Ministry of Finance for endorsement.
8 The HSCC may appoint technical sub- committees, so called "Technical Working Group (TWG)" consisting of members from relevant ministries and institutions, for in-depth review, recommendations and reformulation on any matter related to GAVI-CSO application.
9 Endorse and sign the final version of the GAVI- CSO application, and then submits to the Ministry of Health, National Planning Board, and Ministry of Finance for endorsement.

[1] Minutes from HSCC meetings related to HSS should be attached as supporting documentation, together with the minutes of the HSCC meeting when the application was endorsed. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

10. Supervising and monitoring the implementation of the GAVI-HSS and GAVI-CSO activities, to ensure future HSS initiatives are integrative and complementary;

11. Oversee and review the preparation of Annual Progress Reports to the GAVI Alliance on the outcomes of HSS and other support.

To the applicant

• *Next, please describe the process your country followed to develop the GAVI HSS application (Table 1.2)*

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

The HSCC, and specifically its chairman, Dr Arum Atmawikarta, have provided oversight of the application development process, and the parallel work on the CSO application. Each meeting of the HSCC received a progress report from the Core Team (see below)

Who led the drafting of the application and was any technical assistance provided?

A Core Team was created composed of representatives of the Directorates of EPI, Maternal Health, Child Health, Health Promotion and Human Resources, under the chairmanship of the head of the Planning Bureau, Ministry of Health. Day to day leadership was exercised by the head of the International Relations section of the Planning Bureau, whose staff performed secretariat functions for the Core Team. Staff of UNICEF, WHO and JICA participated in meetings of the Core Team. This Core Team has led the process from the outset, and in particular after the withdrawal of local consultants originally engaged it was this group which developed a new logical framework and the activities and budget derived from it. Advice was received from the World Bank lead on GAVI that there were deficiencies in the original situation analysis and intervention logic, and the Core Team acted on this. Subsequently, the World Bank offered the services of an international health economist who assisted with the final drafting. A new local consultant was also engaged, primarily to work on the CSO application.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

Between January and June 2007, there were various preparatory meetings. From June, local consultants were engaged to develop the situation analysis and identify strategic interventions. The Core Team was constituted in August 2007, with the intention of submitting an application for October 2007. However, this target date was not achieved. In early October, the HSCC was reviewing recommendations from UNICEF and USAID on ways of overcoming the barriers to increasing immunization coverage. Planning moved into a new, more intensive, phase from mid-December onwards, which resulted in the outline of the present application being developed by mid-January. Thereafter, there was an intense process of internal consultation with the technical units of the Ministry of Health, and with the Ministry of Finance on flow of funds issues. The outline proposal was presented to the HSCC on 31 January 2008 to general approval. Workshops were held over successive weekends on 7-8 February and 15-17 February, the latter involving representatives from the five provinces included in the proposal and WHO/SEARO officials as well as all the consultants assisting the process. As a result of these workshops, a more detailed account of the proposed activities was presented to the HSCC meeting on 19 February, which also reviewed the applications on Form C from CSOs and the recommendations

of the Technical Working Group. In the light of observations made at this meeting, new information on fund channelling regulations, and the comments of peer reviewers, modifications were made to the proposal which resulted in the final form of the application presented to the HSCC on 29 February

Who was involved in reviewing the application, and what was the process that was adopted?

The process involved in-country internal review by the HSCC during the entire development of the application, and external review of the near-final draft by academic institutions and international partners. The external reviewers were Dr Mardiati Nadjib from the Faculty of Public Health of the University of Indonesia, and Dr Robert Tilden, consultant to the Asian Development Bank in Indonesia. Due to the very compressed timescale available, the reviewers had strictly limited time in which to make their comments.

Who approved and endorsed the application before submission to the GAVI Secretariat?

After endorsement by the HSCC, the application was approved by the Ministry of Health and the Ministry of Finance before it was submitted to the GAVI secretariat.

To the applicant

- *Please describe overleaf the roles and responsibilities of key partners in the development of the GAVI HSS application (Table 1.3).*

Note: Please ensure that all key partners are included; the Ministry of Health; Ministry of Finance; Immunisation Program; bilateral and multilateral partners; relevant coordinating committees; NGOs and civil society; and private sector contributors. If there has been no involvement of civil society or the private sector in the development of the GAVI HSS application, please explain this below (1.4).

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Director, Community Health & Nutrition	National Planning Board	Yes	Chairman of HSCC; provides leadership and policy direction to the overall HSS planning process; works with related Ministries to ensure HSS plan and overall National Health Strategy are supported.
Director, Multilateral Financing	National Planning Board	Yes	Works with related Ministries to ensure health policy elements are in line with macroeconomic plans and National Health Strategy; gives input into financial management of HSS funding.
Head, Bureau of Planning & Budgeting	Ministry of Health	Yes	Vice Chairman of HSCC, provides leadership and health policy direction to the HSS planning process; builds effective coordination with other units in MoH and international partners.
Director, Surveillance Epidemiology & Immunization	Ministry of Health	Yes	Provides immunization policy direction to the HSS planning process; works with related units in MoH and other HSCC

			members to ensure HSS plan in line with comprehensive Multi Year Plan (cMYP); helps in setting immunization outcome and impact indicators.
Director, Maternal Health	Ministry of Health	Yes	Provides maternal health policy direction to the HSS planning process; helps to identify supportive activities needs in HSS plan; helps in setting maternal health outcome and impact indicators.
Director, Child Health	Ministry of Health	Yes	Provides child health policy direction to the HSS planning process; helps to identify supportive activities needs in HSS plan; helpd in setting child health outcome and impact indicators.
Chief, Center for Health Promotion	Ministry of Health	Yes	Provides leadership and health promotion policy direction to the GAVI-CSO planning process; builds effective coordination with other units in MoH and related CSOs to ensure the CSO proposals are in line with HSS plan and Health National Strategic Plan.
Chief, Center for Health Analysis and Development	Ministry of Health	Yes	Provides health national analysis and health policy direction to the HSS planning process; helps in developing criteria for choosing the project locations; ensures the HSS plan is in line with Health National Strategic Plan.
Chief, Center for Health Training	Ministry of Health	Yes	Help in identify training needs and defines in-service curriculum for provider training and curriculum for community based training; helps in setting outcome and impact indicators for HSS plan.
Chief, Center for Planning and Management of Human Resources for Health	Ministry of Health	Yes	Provides HRH development policy direction to the HSS planning process; helps to identify HRH needs; helps in setting outcome and impact indicators for HSS plan.
Chief, Directorate of Loan Management	Ministry of Finance	Yes	Works with other HSCC members and related Ministries to ensure the financing elements of HSS plan are in line with macroeconomic plans and National Financing Strategy; assists in costing HSS plan and gives input into financial management of HSS funding including auditing of use of funds.
Director of Socioculture and International Organization of Developing Countries	Ministry of Foreign Affairs	Yes	Works with other HSCC members and related Ministries to ensure health policy elements are in line with foreign affairs policy; give input and relevant information of involved international CSOs/NGOs.
Director, Empowerment of Tradition and Social	Ministry of Home Affairs	Yes	Works with other HSCC members and related Ministries to ensure health policy elements are in line with home affairs

Culture of Community			policy; gives input and relevant information of involved national CSOs/NGOs
UN agencies Focal Points for HSS (WHO, UNICEF)	United Nation Agencies	Yes	Works with other HSCC members and related partners to ensure the HSS plan is in line with the UN policy; helps in setting strategic interventions, outcome and impact indicators for HSS plan.
Multilateral agencies Focal Point for HSS (ADB, EU, WB)	Multilateral Agencies	Yes	Works with other HSCC members and related partners to ensure the HSS plan is in line with the other existing supported HSS project in Indonesia; helps in setting strategic interventions, outcome and impact indicators for HSS plan.
Bilateral agencies Focal Point for HSS (JICA, AusAID, USAID)	Bilateral Agencies	Yes	Works with other HSCC members and related partners to ensure the HSS plan is in line with the other existing supported HSS project in Indonesia; helps in setting strategic interventions, outcome and impact indicators for HSS plan.
University Representatives	University	Yes	Helps in setting strategic interventions, outcome and impact indicators for HSS plan; works in Technical Working Group to ensure the CSOs proposals are in line with the HSS plan and cMYP.
CSO/NGO Representatives (PDGI,Muslimat NU, IDAI, IBI, PATH, CARE, PKM, Pramuka, PKK)	Private/Civil Society Organization	Yes	Works with other HSCC members and related partners to ensure the HSS plan is relevant with the community needs; helps in setting strategic interventions, outcome and impact indicators for HSS plan.

To the applicant

- *If the HSCC wishes to make any additional comments or recommendations on the GAVI HSS application to the GAVI Secretariat and Independent Review Committee, please do so below.*
- *Please explain if there has been no involvement of civil society or the private sector, and state if they are expected to have a service provision or advocacy role in GAVI HSS implementation.*

1.4: Additional comments on the GAVI HSS application development process

Comment by HSCC: the HSCC decided at its meeting of 29 February that no additional comment is needed

-How much authority the HSCC will have in overseeing implementation?

The HSCC is expected to have an oversight role in implementation of both the HSS and CSO proposals. Specifically, the HSCC will be expected to review before submission to GAVI the Annual Progress Report, see items 10 and 11 in the HSCC Terms of Reference included above.

Section 2: Country Background Information

To the applicant

• *Please provide the most recent socio-economic and demographic information available for your country. Please specify dates and data sources. (Table 2.1).*

2.1 : Current socio-demographic and economic country information[2]

Information	Value	Information	Value
Population (2008 projection) Calculated from Population Reference Bureau (www.prb.org)	234.8m	GNI per capita (2007) Source:WB Health Public Expenditure Review (forthcoming)	$US 1,280
Annual Birth Cohort (2008) Calculated from PRB data	4.931m	Under five mortality rate (2007) Calculated from PRB and WHO data	43/ 1000
Surviving Infants* (2008) Calculated from PRB data	4.763m	Infant mortality rate (2007) PRB	34/ 1000
Percentage of GNI allocated to Health (2005) Source: WHO	2.7%	Percentage of Government expenditure on Health (2007) Source: WB as above	5.0%

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

To the applicant

• *Please provide a brief summary of your country's Health Sector Plan (or equivalent), including the key objectives of the plan, the key strengths and weaknesses that have been identified through health sector analyses, and the priority areas for future development (Table 2.2).*

2.2: Overview of the National Health Sector Strategic Plan

The Ministry of Health Strategic Plan 2004-2009 first appeared in August 2004, but was revised and reissued in May 2006. The introductory chapter explains the need for revision by reference to various problems and challenges which became heavier, more complex and more unpredictable since the original was prepared. It also explains that the revision was produced by means of four workshops involving all Echelon I and II officials of the Ministry. Following a review of the challenges facing the Ministry, and a declaration of the vision, mission and values underlying its role, the main strategies are identified as:

- Social mobilization and community empowerment for healthy living
- Improved quality of health services
- Improved surveillance of disease threats, and a revised health information system
- Increased health financing

Each of these strategies is elaborated in text and (unquantified) target statements. The first finds its main expression in the *desa siaga* concept, usually translated as "alert villages". The ideal is a community supported, largely volunteer staffed network focused around a modest static health

[2] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested. SEE ATTACHMENT IN ANNEX 1

facility which is responsible both for identifying health needs and threats and mounting an appropriate response in the form of basic services of preventive and promotive care, family planning, pregnancy and delivery care, nutrition, and management of health emergencies. An improved quality of health services is to be brought about by an expansion of the service delivery network, increasing numbers and quality of human resources, and a supportive legal and regulatory framework. The improved health surveillance system is to be implemented by the increasingly active role of the community in identifying and reporting health problems in its area, and developing an outbreak investigation capacity. Increased health financing focuses on three themes: higher budgets for health, eventually reaching 15% of total expenditure at each level of government; health insurance starting with a scheme of health insurance for the poor (*Askeskin*); and facility level fund management. Prioritizing expenditure on prevention and health promotion within government budgets is specified as a target.

This statement of strategies is followed by a much longer section on programs, aligned to the principal budget headings used by the Ministry of Health, and a highly summarized statement of the resources required for implementation of the plan.

There are no known published critiques of the plan. However, it has been observed that the means of implementing the stated policies are not clearly articulated, nor is the mode of interaction with the regions which own and manage most of the provider system in which implicitly the interventions will take place. Moreover, the plan makes very few explicit references to nongovernment providers.

Section 3: Situation Analysis / Needs Assessment

To the applicant

GAVI HSS Support: GAVI HSS support cannot address all health system barriers that impact on immunisation and other child and maternal health services. GAVI HSS support should complement and not duplicate or compete with existing (or planned) efforts to strengthen the health system. GAVI HSS support should target "gaps" in current health system development efforts.

- *Please provide information on the most recent assessments of the health sector that have identified health system barriers. (Table 3.1)*

Note: Assessments can include a recent health sector review (conducted in the last 3 years), a recent report or study on sector constraints, a situation analysis (such as that conducted for the cMYP), or any combination of these. Please attach the reports of these assessments to the application (with executive summaries, if available). Please number them and list them in Annex 1.

Note: If there have not been any recent in-depth assessments of the health system (in the last 3 years), at the very least, a desk review identifying and analysing the key health systems bottlenecks will need to be undertaken before applying for GAVI HSS support. This assessment should identify the major strengths and weaknesses in the health system, and identify where capacity needs to be strengthened to achieve and / or sustain increased immunisation coverage.

3.1: Recent health system assessments[3]

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Indonesia cMYP 2007-2011 (contains SWOT analysis)	Ministry of Health	Comprehensive Multi-Year Plan for immunization. SWOT analysis points up limited program funding,	Finalized 2008

[3] Within the last 3 years.

		lack of IEC and social mobilization activities, lack of advocacy, no regulation of private providers, and cultural constraints in some areas.	
Did the strategy of skilled attendance at birth reach the poor in Indonesia?	WHO	Access to maternal and neonatal child health services for the poor women had been improved through the village midwife program. However, the gap in access to potentially life-saving emergency obstetric care widened. The research emphasizes the importance of understanding the barriers to accessing emergency obstetric care and of the ways to overcome them, especially among the poor.	2006
Study on human resources for health	Bappenas (National Planning Board)	The study recognized HRH problems in remote and less developed areas. The study also reviewed the current government policies in relation to HRH (long term, medium term plans and annual priority program). Some challenges to be dealt with include supports to HDI improvement, response of HRH system to the demographic setting, quality of health professionals, type of incentives expected by health workers, management of HRH (planning, recruitment and deployment), etc.	2005
Resident midwives help avert maternal deaths when financial barriers are removed.	Immpact - PRB	The research was conducted in 2 districts in Central Java Province in 2005. The research found that the availability of village midwives had increased number of deliveries by skilled attendant but the coverage remained low, as the rural villages has fewer midwives than the urban. Village midwives reduce maternal deaths by identifying complications, making timely referrals, and facilitating access to hospitals. However, the rich families tend to benefit from health services more than poorer families. The research recommended providing incentives for midwives to work and live in remote villages, and improving access and affordability of maternal care services for the poor.	2007
Health Systems Strengthening and Policy Options Background Paper	GOI and international partners	Paper proposing systematic review of health sector, responding to a GOI request. Observes deterioration in community health and nutrition programs since 1990s;	2007

		increasing needs prompted by demographic and epidemiological transitions; low level, inequity and inefficiency of funding public providers, and heavy reliance on out of pocket payment; low numbers of health personnel, maldistribution and low morale reflected in absenteeism and dual practice	
Indonesia Health Public Expenditure Review	World Bank	Identifies weak outcomes for maternal mortality and child nutrition, in contrast to impressive gains in infant and child mortality. Attributes failings to historic under-funding, identifies rapid recent rise in public expenditure but persisting equity and efficiency issues.	2007
Indonesia: Sub-National Health System Performance Assessment	National Institute of Health Research and Development, MoH in collaboration with WHO and Statistics Indonesia	The methodology adapted WHO's health system performance assessment framework for international comparisons to inter-district comparisons. Findings included wide variability in performance between districts, pervasive concerns for quality, including basic amenities in health facilities, choice of provider, patient autonomy, and information system weaknesses	2005

To the applicant

- *Please provide information on the major health system barriers to improving immunisation coverage that have been identified in recent assessments listed above. (Table 3.2)*
- *Please provide information on those barriers that are being adequately addressed with existing resources (Table 3.3).*
- *Please provide information on those barriers that are not being adequately addressed and that require additional support through GAVI HSS (Table 3.4).*

3.2: Major barriers to improving immunisation coverage identified in recent assessments

Recent assessments identify a series of impediments to delivery of public health services including immunization. Consistently identified are a lack of support for health services in general and public health services in particular from regional governments which since decentralization in 2000 are largely responsible for the management and financing of health service delivery; a historic low level of public expenditure on health, so that notwithstanding rapid recent increases Indonesia remains a low spender on health, and within that a low proportion of expenditure for public health compared with medical care, and a low proportion for operational compared with capital expenditure; weaknesses in human resources extending from low practitioner/population ratios, maldistribution with rural and remote areas being least staffed, inadequate skills attributable to weak professional training and low motivation; major weaknesses in the information system, including such basic data as the denominator populations for administrative areas; weaknesses in planning and supervision of services associated with fragmented funding; physical and geographic barriers to access in low population density areas, particularly mountainous and remote island locations; flagging and

variable levels of community support to outreach service delivery points; and inadequate popular demand for preventive services, owing to lack of knowledge or occasionally the circulation of inaccurate rumours concerning the side effects of interventions. There is a pronounced tendency for official plans and procedures to take account only of the public provider system, leaving all forms of non-government providers isolated and unregulated.

3.3: Barriers that are being adequately addressed with existing resources

A significant change has occurred since the turn of the present century, and particularly since the election of the current government with its welfare orientation. While many of the barriers described above can be traced back to the historic chronic under-funding of the public sector in health, by contrast public spending on health has increased rapidly in recent years, both in absolute terms and as a share of GDP or total public expenditure, and this trend is set to continue. However, the increases are from a historically very low base, so that even now (2008) Indonesia remains a low spender on health by international comparisons.

Some of the other barriers derive from the design of decentralization. The ambiguity over the location of responsibility among the levels of government for health service functions has been addressed by a series of amendments to the original legislation. Across all sectors, the effort is being made to define the obligatory functions of regional (province and district) governments, and to specify the minimum service standards that they should attain.

Current Ministry of Health policy has two salient features, corresponding to two of the four directions set out in the current strategic plan. The first of these is *desa siaga*, or alert villages, which is essentially a drive to re-animate the lowest tier of the public sector delivery system, inspired by anxieties about avian influenza, stagnation in MCH indicators and outbreaks of polio and measles. The other is *askeskin* (state subsidised health insurance for the poor). This is a scheme designed to improve access to medical care for the poor; by implication, it should have no direct impact on immunization, since this is historically a service free at the point of delivery, but there may well be an indirect effect in encouraging greater use of public health centre services.

Indonesia is not heavily dependent on external aid in its health sector, but there are health system strengthening projects funded by a range of donors, usually limited in coverage to selected provinces or in scope to selected topics.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

The barriers which it is proposed to address with GAVI HSS support are only a subset of those described above. Given limitations of time and funding, it has been decided to focus on interventions which are expected to have tangible impact within two years, and which are closely aligned with prominent government policy initiatives. The first barrier to be addressed is the lack of community support for immunization and other MCH services. This requires a combination of community organization and provision of appropriate IEC materials. The second barrier is the limited capacity of frontline health personnel to organize and deliver effective outreach services which depend on the linkage between the health providers and the communities they serve. The third barrier that will be addressed is the prevailing separation between the public provider system and the CSOs of various types which serve the same catchment populations. The fourth barrier, the inadequate motivation of both community volunteers and salaried staff, will be addressed by pilot schemes to provide incentives. The first two of these are projected to receive the greatest weight of attention and budget. The remaining two will be addressed in a more selective fashion, according to the availability of CSO partners and the opportunities for operational research.

Section 4: Goals and Objectives of GAVI HSS Support

To the applicant

- *Please describe the goals of GAVI HSS support below (Table 4.1).*
- *Please describe (and number) the objectives of GAVI HSS support (Table 4.2). Please ensure that the chosen objectives are specific, measurable, achievable, realistic and time-bound.*

4.1: Goals of GAVI HSS support

The overall goal of HSS support is improved health status of mothers, infants and children.

It is anticipated that this improvement will be manifested through favourable movements in a range of indicators both of outcomes (such as the infant and under-five mortality rates, and the maternal mortality ratio) and processes, such as immunization coverage and attended deliveries, which are assumed to be highly correlated with outcomes. It is recognised that if interventions are made at the health system level, rather than the narrower programmatic level, the effects will be more diffuse. It is assumed that one of the consequences which will follow from adoption of this proposal will be an increase in immunization coverage, leading to a reduction in death and disability from immunizable diseases, but there should also be impacts on infant and child nutrition, management of diarrheal disease and home hygiene, and the health of women through pregnancy and childbirth, because the mechanisms involved go beyond a single program and the personnel involved are polyvalent.

4.2: Objectives of GAVI HSS Support

Improved coverage of maternal and child health services, including immunization, through:

1. Community mobilization
2. Capacity building of MCH program management at district and health centre levels
3. Partnerships with CSOs
4. Pilot projects on contractual relationships and incentive mechanisms

The community mobilization contribution to improved service coverage would operate through two main mechanisms: community members properly informed on health issues would have improved capacity individually and collectively to protect their own health by spontaneous action on home hygiene, nutrition and behaviours; and they would more readily take up the offer of MCH services from trained providers, including immunization. By end 2009, this proposal will result in the addition of 18000 to the number of trained kaders, and the establishment or revival of 60,560 posyandu delivering MCH outreach services including immunization

The contribution of improved management capacity among the providers of MCH services would be a more effective and acceptable offer of services to the communities, leading to increased take up of services. The *bidan di desa* or village midwives have a pivotal role both in community mobilization efforts and as principal providers of outreach services. By the end of 2009, this proposal will result in the training of 17835 staff engaged in outreach services, and the adoption of good MCH management practices in 1189 health centres in 62 districts.

The contribution of partnerships with CSOs (or more broadly non-government actors, a term which also includes private providers) is that it enlists more resources for community mobilization or service delivery efforts. Effective partnerships will be established in all 86 districts by the end

of 2009.

The contribution of operational research is essentially an addition to the body of knowledge available to health service managers. It will produce benefits over a long time scale with applicability on a national scale. By end 2009, reports should be available on the experience of piloting incentive mechanisms in up to 6 districts located in 3 provinces (excluding Papua and West Papua), and the experience of contracting a non-government provider in one or more locations in Papua or West Papua.

Section 5: GAVI HSS Activities and Implementation Schedule

To the applicant

- *For each objective identified in Table 4.2, please give details of the major activities that will be undertaken in order to achieve the stated objective and the implementation schedule for each of these activities over the duration of the GAVI HSS support (Table 5.2 overleaf).*

Note: GAVI recommend that GAVI HSS supports a few prioritised objectives and activities only. It should be possible to implement, monitor and evaluate the activities over the life of the GAVI HSS support.

Note: Please add (or delete) rows so that Table 5.2 contains the correct number of objectives for your GAVI HSS application, and the correct number of activities for each of your core objectives.

Note: Please add (or delete) years so that Table 5.2 reflects duration of your GAVI HSS application

To the applicant

- *Please identify below how you intend to sustain, both technically and financially, the impact achieved with GAVI HSS support (5.1) when GAVI HSS resources are no longer available.*

5.1: Sustainability of GAVI HSS support

The overall capacity of the system to sustain the incremental expenditure initiated by GAVI HSS support is beyond question. Public expenditure on health in constant prices has been growing at an average annual rate in excess of 15% since the year 2000 (source: World Bank, Indonesia, Health Public Expenditure Review, forthcoming). Estimated public expenditure on health in 2007 is Rp39 trillion, or US$4.2 billion. The priority given to health is shown by the fact that its share of total public expenditure has almost doubled, from 2.6% in 2001 to 5% in 2007.

This conclusion holds when the focus is narrowed to the specific provinces and districts included in the proposal. In aggregate, the 5 provinces account for approximately 20% of the total population

and 20% of the number of districts in Indonesia. Their combined public expenditure on health, including the attributable share of expenditure from the national budget, is over US$800 million annually, so that the capacity to sustain a further $12 million annually is evident. Almost two thirds of total public expenditure on health is spent directly from provincial and district budgets, but in addition, more than half of centrally budgeted expenditure is incurred to support services at provincial and district level. While the capacity to support higher expenditure is clear, the political will to do so is less evident. It is for this reason that one of the activities included in the proposal is advocacy to district governments and politicians so that they include adequate support for public health activities in the district budgets.

With regard to technical sustainability, the institutional developments financed in the initial phase of support, including community mobilization, partnerships with CSOs, the networking developed between district authorities, health providers and communities, improved micro planning capacity, monitoring and evaluation of activities, the training and re-tooling of key personnel plus the development of IEC and training materials, should ensure that the necessary elements are in place.

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1		Year 2			
	-2008		-2009			
	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1. Community Mobilization to support MCH						
1.1. Assessment and mapping of existing situation relating to community activities in the selected provinces	x	x				
1.2. Selection of kaders (CHWs) within their own communities and village level training of kaders using existing training materials	x	x	x	x		
1.3. Development, procurement and distribution of IEC materials and equipment including Buku KIA (MCH handbook)	x	x	x	x		
1.4. Sensitization of community and religious leaders to MCH issues including immunization, and the role of kaders		x	x	x		
1.5. Provision of small grants for the operational costs of community level collective action			x	x	x	
Objective 2. Improvement of Management Capacity of MCH personnel						
2.1. Needs assessment by MoH/PHO/DHO staff of MCH management issues at district and puskesmas levels	x	x				
2.2. Advocacy by MoH/PHO staff to district administration and political leaders for adequate budgetary support of MCH activities		x	x	x	x	
2.3. Development and distribution of management guidelines, tools (such as supervision checklists) and training materials		x	x	x		
2.4. Plan, design and conduct training of District Training Teams who will perform the team training at puskesmas level		x	x	x		
2.5. Puskesmas team training in micro-planning, supervision, M&E, surveillance and managing community development		x	x	x		
2.6. Provision of operational cost to support implementation of improved management in the topics of the team training					x	
Objective 3. Partnership with Non Government Organizations (NGO)						
3.1. Identification of partners, development of action plans, formulation of MOUs	x	x				
3.2. Strengthening coordination, implementation of MOU, including regular consultations and joint monitoring and evaluation		x	x	x	x	
3.3. Engaging private sector partners in MCH service delivery, including orientation to government policies on MCH, and sensitization of TBAs and private midwives		x	x	x	x	
Objective 4. Operational research on critical barriers						
4.1. Pilot project on contracting health service provision for an under-served locality in Papua	x	x	x	x	x	
4.2. Operational research on incentives for kaders and salaried staff of puskesmas	x	x	x	x	x	

Section 6: Monitoring, Evaluation and Operational Research

To the applicant

- *All applications must include the three main GAVI HSS impact / outcome indicators:*
i) National DTP3 coverage (%) ii) Number / % of districts achieving ≥ 80% DTP3 coverage[4] *iii) Under five mortality rate (per 1000)*

- *Please list up to three more impact / outcome indicators that can be used to assess the impact of GAVI HSS on improving immunisation and other child and maternal health services.*

Note: It is strongly suggested that the chosen indicators are linked with proposal objectives and not necessarily with activities.

- *For all indicators, please give a data source, the baseline value of the indicator and date, and a target level and date. Some indicators may have more than one data source (Table 6.1).*

Note: The chosen indicators should be drawn from those used for monitoring the National Health Sector Plan (or equivalent) and ideally be measured already (i.e. not an extra burden to measure). They do not have to be GAVI HSS specific. Examples of additional impact and outcome indicators are given in the tables below. It is recommended that when activities are implemented primarily at sub-national level that indicators are monitored, to the extent possible, at sub-nationally as well.

Examples of Impact Indicators

- Maternal mortality ratio

Examples of Outcome Indicators

- National measles coverage
- Proportion of districts with coverage at 80% or above
- Hib coverage
- HepB coverage, BCG coverage
- DTP1-DTP3 drop-out rate
- Proportion of births attended by skilled health personnel
- Antenatal care use
- Vitamin A supplementation rate

Intervention	Possible indicators
Immunisation	National measles coverage; proportion of districts with coverage at 80% or above; BCG coverage; Polio 3 coverage; Hib coverage; HepB3 coverage
Maternity care	Antenatal care use; skilled birth attendance; tetanus toxoid 2 or more doses; caesarean section rate; postnatal care
Family planning	Contraceptive use among women
Treatment of sick children	oral rehydration therapy and continued feeding for children with diarrhoea; Care seeking for pneumonia; Antibiotic treatment for pneumonia
	Breastfeeding rate; (start on first day, exclusive at 0-3 months, supplements at 6-9 months); vitamin A supplementation rate to children 6-59 months (within last 6 months) and postpartum to mother within 8 weeks
Water/sanitation	Access to safe water source; adequate sanitary facilities
Tuberculosis	DOTS treatment coverage (treatment success rate times case detection rate)
Malaria	Children with fever receiving anti-malarials; children sleeping under ITN

[4] If number of districts is provided than the total number of districts in the country must also be provided.

AIDS	% of HIV-positive pregnant women receiving ARVs; PMTCT among pregnant women

To the applicant

- *Please list up to 6 output indicators based on the selected activities in section 5. (Table 6.2).*
- *For all indicators, please give a data source, the baseline value of the indicator and date, a target level and date, as well as a numerator and denominator. Some indicators may have more than one data source (Table 6.1).*

Note: Examples of output indicators that could be used, with the related numerator, denominator (if applicable) and data source are shown below. Existing sources of information should be used to collect the information on the selected indicators wherever possible. In some countries there may be a need to carry out health facility surveys, household surveys, or establish demographic surveillance. If extra funds are required for these activities, they should be included.

Examples of Output Indicators

Indicator	Numerator	Denominator	Data Source
Systematic Supervision	Number of health centres visited at least 6 times in the last year using a quantified checklist	Total number of health centres	Health facility survey
Knowledge of Health Workers	Mean score of health workers in public and NGO health centres on verbal knowledge test including case scenarios		Health facility survey
Drug availability index	Average number of ten selected essential drugs that are in stock in sampled health centres		HMIS & Health facility survey

Indicator	Data Source	Baseline Value	Source[6]
1. National DTP3 coverage (%)			
2. Number / % of districts achieving ≥80% DTP3 cov			
3. Under five mortality rate (per 1,000)	DHS	46	Directorate of child health
4. Infant mortality rate (per 1,000)	DHS	35	Directorate of child health
5. Attended delivery rate (%)	Routine report	%	Directorate of maternal health

6.2: Output Indicators

Indicators

Indicator	Numerator	Denominator
1. Percentage of community health workers (kaders) in target sub-districts trained in community mobilization	Number of community health workers in target sub-districts trained in community mobilization	Total number of community health workers in the target districts
2. Percentage of villages which received operational	Number of villages in target sub-districts which	Total number of villages in the target sub

5 If baseline data is not available indicate whether baseline data collection is planned and when

6 Important for easy accessing and cross referencing

cost support	received operational cost support	districts				
3. Percentage of the target sub-districts with staff trained in management	Number of the targeted sub-districts with staff trained in management	Total number of targeted sub-districts	Provincial Health Office compilation of DHO reports	Not known. Will be established in initial assessmen t	Provincial Health Office	2
4. Percentage of the sub-districts regularly following good management practices after training	Number of the sub-districts institutionalizing practices after training	Total number of sub-districts targeted for management training	Provincial Health Office compilation of DHO reports	Not applicable	Provincial Health Office	N a
5. Percentage of the target districts having joint regular meeting with CSOs (at least 3 p.a.)	Number of the target districts having regular meeting with CSOs	The number of target districts in the target provinces	Provincial Health Office reports	Not applicable	Provincial Health Office	N a

6.3: Data collection, analysis and use

6.4: Strengthening M&E system

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	Data is collected through the existing reporting system.	Data is analyzed through routine system by the central government.	The central government uses this data as input to periodical M&E of EPI programme
2. Number / % of districts achieving ≥80% DTP3 coverage	Data is collected through the existing reporting system	Data is analyzed through routine system in the central and provincial government.	The central government uses this data as input to periodical M&E of EPI programme.
3. Under five mortality rate (per 1000)	Data not routinely available, no universal vital statistics system. Periodically estimated from Census and DHS	Data is analyzed by demographers in Central Statistics Board and others.	The central government uses this data as a major indicator of health status
4. Infant mortality rate (per 1,000)	As above	As above	As above
5. Attended deliveries rate	Data is collected through the existing reporting system. In addition, a new DHS will be referred to.	Data is analyzed through routine system in the central and provincial government.	The central and provincial government use this data as input to periodical M&E of the maternal health program.
Output			
1. Percentage of community health workers trained in community mobilization	Sub-district and health centers will collect the data and send to district health office	District and province health office will consolidate and analyze the data	Province and district level will use as key input to program monitoring
2. Percentage of villages which received operational cost support	Sub-district and health centers will collect the data and send to district health office	District and province health office will consolidate and analyze the data	Province and district level will use as key input to program monitoring
3. Percentage of the sub-districts with staff trained in management	District health offices send the information to provincial health offices	Provincial health offices will consolidate and analyze the data	Province and district level will use as key input to program monitoring
4. Percentage of the sub-districts institutionalizing practices after training	District health offices send the information to provincial health offices	Provincial health offices will consolidate and analyze the data	Province and district level will use as key input to program monitoring
5. Percentage of the districts	District health	Provincial health	Province and district

having joint regular meeting with CSOs	offices send the information to provincial health offices	offices will consolidate and analyze the data	level will use as key input to program monitoring

The weaknesses in the information system were identified in section 3 above as one of the major deficiencies of the health system in Indonesia. There is no system of universal birth and death registration, so that vital statistics can only be estimated periodically from Census data and periodic intensive surveys such as the Demographic and Health Survey. Administrative reporting suffers from a number of pervasive problems, including fragmentation among vertical programs, coverage limitation to the main public provider system, use of inconsistent definitions, weak analytical skills, and widespread non-compliance. Despite these problems, it was decided that given the budget and timeframe applicable to the HSS application, the information system would not be a priority system component to address.

There will however be a systematic effort to improve the processes of monitoring and evaluation as they relate to HSS activities. For each of the main interventions, the first step is to assess the current situation implying the systematic collection of relevant data and the establishment of a baseline against which subsequent progress can be measured. The collection, collation and transfer of data on the output indicators will be a responsibility of the technical teams at each level, district, provincial and national, culminating in a periodic report to the HSCC. Of the outcome indicators, three are already routinely collected on a national basis; it will be necessary to extract the specific information related to target areas. For the remaining two, the infant mortality rate and under-five mortality rate, while new estimates from the Demographic and Health Survey are expected shortly, no further data will become available within the period of the application.

The obligation to monitor and evaluate performance with the resources provided by GAVI is reflected in a significant budgetary allocation for this purpose. In addition to the provision explicitly labeled as monitoring, a significant proportion of the funds for activities 1.1, 2.1 and 3.1 will be applied to developing the baseline data.

6.5: Operational Research

Operational research on a pilot basis will be carried out on two problematic issues, incentive schemes and contracting of non-government health service providers.

According to our problem analysis, the low motivation of community health workers and health personnel in the health center is one of the barriers to improvement of health service delivery, reflected in the low coverage of MCH services including immunization. Different types of incentive, monetary and non-monetary, will be tried and investigated on a sample of community health workers and health personnel in the health centres. This research will be contracted to a university department with experience in human resources for health issues. Assuming positive findings, the conclusions of the pilot research will be communicated and recommended for widespread adoption.

In Papua, the most serious barrier to improvement of health service delivery is the absolute shortage of health personnel. In some cases, it is reported that buildings and equipment are available, but are unused. A potential solution to this grave problem is to contract a non-government organization with its own personnel to provide services at such sites. There is a model for such contracting which has been applied in the tsunami-affected area of Nias, North Sumatra, but the pilot envisaged would be a first for Papua. Again, the services of the university department responsible for developing the Nias model would be engaged to assist in formulating an appropriate contract.

Section 7: Implementation Arrangements

To the applicant

- *Please describe how the GAVI HSS support will be managed (Table 7.1). Please also indicate the roles and responsibilities of all key partners in GAVI HSS implementation (Table 7.2).*

Note: GAVI encourages aligning GAVI HSS with existing country mechanisms. Applicants are strongly discouraged from establishing a project management unit (PMU) for GAVI HSS. Support for PMUs will only be considered under exceptional circumstances, based on a strong rationale.

7.1: Management of GAVI HSS support

Management mechanism	Description

Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	The successful operation of the activities contained in this proposal will require the creation of machinery at national, provincial and district levels, following the standard practices of the Government of Indonesia. At national level, this machinery consists of an Executing Agency, which will be the GAVI Secretariat in the Directorate General of communicable Disease Control and Environmental Health. The function of the Executing Agency is to receive the funds transferred from GAVI, and to distribute them to the Implementing Agencies on the direction of the Technical Committee. The Implementing Agencies will be the Secretary to the Directorate General for Community Health, which supervises the Directorates of Maternal Health and Child Health; the Director of Health Promotion; and the Head of the Center for Planning and Management of Human Resources for Health. These Implementing Agencies will develop the detailed implementation plans and guidelines for carrying out the activities at sub-national levels, and will directly produce some key inputs, such as IEC materials in Activity 1.3, the management tools in Activity 2.3 and the training of trainers in Activity 2.4. Coordination of the activities of the Implementation Agencies will be assured by a Technical Committee, consisting of representatives of the Executing Agency and the Implementing Agencies, under the chairmanship of the Planning Bureau. The Technical Committee will be responsible for ensuring the allocation of funds, the monitoring of activities, and reporting to the HSCC. The HSCC will provide overall supervision, and in particular it will approve the Annual Report made to GAVI. At provincial level, overall responsibility will be assumed by the head of the planning division of the PHO (Provincial Health Office). This officer will assemble a team of officers representing functions of the Implementing Agencies at national level (maternal health, child health, health promotion, and human resource development). The principal function of the province level is to sensitize the districts, to monitor their performance, and in the cases of Papua and West Papua, to select districts in which community mobilization efforts will be focused. Funds for provincial level activities will be transferred directly to them by the Executing Agency. The majority of activities will be implemented at district and sub-district levels. In some districts there is a planning division within the DHO (District Health Office), in others the function is subsumed in the role of the head of administration. As at provincial level, the responsible officer will assemble a team of DHO staffers to coordinate and conduct the activities, to supervise community mobilization actions at sub-district level, and to carry out the management training and CSO partnership functions. The districts will receive funding for activities at their level and below directly from the Executing Agency.

Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	The role of the HSCC is to provide overall supervision of GAVI HSS activities. It will receive periodic reports from the Technical Committee, and will give advice as necessary. It will review and endorse the Annual Report to GAVI
Mechanism for coordinating GAVI HSS with other system activities and programs	The principal mechanism for ensuring coordination between GAVI HSS activities and other system activities is the deliberations of the HSCC, which contains representatives of all the concerned units of the Ministry of Health. Within their area of technical competence, each of the Implementing Agencies will be responsible for coordination between GAVI HSS and other related activities. Similarly at provincial and district levels, the technical officers will be responsible for linkages with related ongoing activities.

7.2: Roles and responsibilities of key partners (HSCC members and others)

7.3: Financial management of GAVI HSS support

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Chairman	National Planning Board	Yes	Coordinating the HSCC members in performing their functions and roles on health matters as well as for GAVI proposals
Vice Chairman	Bureau of Planning and Budgeting, MoH	Yes	Bring recommendations and advice from the HSCC forum to the Minister of Health for further decision and approval
Directors of technical departments	MoH	Yes	As HSCC members, provide advice and recommendation on policy and strategies in relation to areas of technical concern, ensure coordination with activities in related programs.
Heads of agencies, or technical staff	Multilateral or bilateral aid and technical agencies	Yes	As HSCC members, participate in overall supervision of HSS activities; provide advice and recommendation on policy and strategies, and information on related activities.
Representatives of agencies	CSOs	Yes	As HSCC members, participate in overall supervision of HSS activities; provide advice and recommendation on policy and strategies, and information on related activities.
Head of Planning Division	Provincial Health Office	No	Formulation of provincial action plan, coordination of district plans, monitoring, evaluation and supervision of implementation of district level activities
Head of Planning or Administration	District Health Office	No	Formulation of district action plan, coordinate technical staff responsible for the implementation of the project activities including staff at sub-district level, provide reports on activities to provincial level

CSOs at district level	Various	No (may be affiliated to national level members)	Enter into agreements with DHOs for combined action in community mobilization and/or service delivery in MCH activities, including immunization
Private health providers	Various	No	Receive guidance on MoH policies and good practices in relation to MCH services
Universities	University of Indonesia, University Gaja Mada	No	Provide contracted technical assistance in operational research on contracting of private providers and incentives

To the applicant • *Please give the financial management arrangements for GAVI HSS support. GAVI encourages funds to be managed 'on-budget'. Please describe how this will be achieved (Table 7.3).* • *Please describe any procurement mechanisms that will be used for GAVI HSS (Table 7.4).*

Mechanism / procedure	**Description**
Mechanism for channelling GAVI HSS funds into the country	Channelling GAVI HSS funds will follow GOI regulations as in the government regulation no: 02 year 2006 and the regulation of DG of Treasury – MoF no: 67 year 2006. The basic principle within this regulation is that all foreign grants must be written in the national budget document. 1. The Executing Agency (CDC-MoH), through the Secretary General, request the opening of new account and the registration number to the MoF (DG of Treasury). 2. Parallel with that process, the CDC-MoH, also through the Secretary General, request the MoF (DG of Budget) that GAVI-HSS funds to be written in the CDC- national budget document. 3. The CDC-MoH verifies the bank account number to GAVI (donor) and request to transfer the agreed amount of fund, as in the letter of approval (considered as the grant agreement). 4. GAVI transfer the money to the CDC-MoH bank account. This will be managed by the existing GAVI secretariat in the CDC-MoH.

Mechanism for channelling GAVI HSS funds from central level to the periphery	GAVI HSS funds will be transferred directly by The GAVI secretariat-CDC-MoH to the bank accounts of selected Provincial Health Offices and the District Health Offices. Funds for health centers, sub districts, and villages will be managed by the DHOs. The amount of the money transferred varies among provinces and districts, in accordance with the agreed schedule and action plans.
Mechanism (and responsibility) for budget use and approval	The implementing units in central and periphery levels should use the GAVI HSS funds to conduct activities that in line with the agreed action plan. The GAVI secretariat-CDC-MoH will be responsible to ensure that the budget will be used on the right track.
Mechanism for disbursement of GAVI HSS funds	The implementing units must send statement of expenditure monthly to GAVI secretariat-CDC-MoH to be verified and recapitulated. The GAVI secretariat-CDC-MoH then send the request of legalization (SPP) to the Special Treasury Office – Jakarta VI (STO-MoF), with attached documents i.e. the recapitulation of the expenditures, the Notice of Disbursement / Debit Advice (NoD/DA) from the donor and the banking statement. The STO-MoF evaluate the appropriateness of the request and match to the CDC- national budget document, and evaluate that the remaining amount in the banking statement plus the realization of expenditure must be balance with the total amount of grant as mentioned in the NoD/DA. Using this consideration/evaluation, the STO-MoF issue a Withdrawal Application (WA) as the document of the written document of national budget realization. Based on the WA, NoD/DA and the banking statements, STO-MoF then will issue the letter of accounting/legalization order (SP3). Disbursement of GAVI HSS funds from the implementing units will be done in monthly basis. At the country level, the disbursement of GAVI HSS funds will be conducted on quarterly basis.
Auditing procedures	The auditing procedures will use the GOI regulation on audit mechanism. An internal audit will be conducted by Inspectorate General of MoH. An external audit will be conducted by the State Audit Authority (BPK). The audit process will be done on annual basis, approximately three month after the closing fiscal year, and maximum within six month after the project completion date.

7.4: Procurement mechanisms

The procurement method will use the mechanism set up by the Presidential Decree no. 80 year 2003 on guidelines of procurement of goods/services in government institutions, and the revised version as on the Presidential Decree no. 61 year 2004.

A. Procurement of Consultant Services: Selection of the consultants (team or individual)

There are 5 methods in selecting the consultants to provide expertise services, i.e. the evaluation based on quality method, the evalution based on quality and cost method, the evaluation based on budget, the evaluation based on the lowest cost and the evaluation based on direct assignment. This project plan to use 2 of the 5 methods in order to select the consultant/experts in providing the required technical assistance, with steps as follow:

1. Consultant/Expert Team : the method used is the Selection Based on Cost and Quality, with the following steps:

1). Announcement of pre qualification;
2). Collection of pre qualification document;
3). Submission of pre qualification document;
4). Evaluation of pre qualification document;
5). Conclusion of the evaluation result of the pre qualification document;
6). Announcement of the pre qualification result;
7). Complaint period of pre qualification;
8). Invitation to the short-listed consultant;
9). Collection of Selection Document;
10). Clarification;
11). Arrangement of official minutes of clarification on selection document and its amendment;
12). Submission of proposal;
13). Opening of the administration and technical proposal (envelop I);
14). Evaluation on administration and technical proposal;
15). Conclusion on technical ranking;
16). Announcement of the result of the technical ranking;
17). Invitation to the opening of proposal for participants who pass the technical evaluation;
18). Opening of the financial proposal (envelop II);
19). Evaluation of financial proposal;
20). Assessment of the combination of the technical and financial proposal;
21). Decision on the winner;
22). Publication of the winner;
23). Challenge period;
24). Clarification and negotiation on technical and financial proposal with the winner;
25). Assignment of the winner;
26). Signing contract

2. Individual Consultant: the method used is the Direct Selection, with the following steps:

- Invitation to the selected consultant along with the pre qualification document and direct selection document;
- Submission and evaluation of pre qualification document, with clarification included;
- Submission of administration, technical and financial proposals in one envelop;
- Opening and evaluation of proposal by the bidding committee;
- Clarification and negotiation on technical and financial matters;
- Assignment of the winner;
- Signing contract.

B. Procurement of Goods and other services
The procurement of goods and services in this project will use the general bidding method, by conducting open announcement through mass media or official announcement board for public information so the interested and qualified business community can join with bidding process. For efficiency in procurement process, procurement of EIC materials, the procurement will be conducted in central level while the procurement of other equipment will be conducted by provinces.

The mechanism of submitting the proposal will use the two envelop methods, i.e. submission of the proposal document of administration and technical requirements in the first sealed envelop, while the proposed budget will be in the second sealed envelop, to be submitted to the procurement committee. The procedures of selection of goods/service use two types of process, as follow:

a. With pre qualification process 1). announcement of pre qualification; 2). collection of the document of pre qualification; 3). Submission of the document of pre qualification; 4). evaluation of the document of pre qualification; 5). decision of the result of pre qualification; 6). announcement of the result of pre qualification; 7). Challenge period during the pre qualification process; 8). invitation for bidders who pass the pre qualification; 9). collection of the general bidding document; 10). Clarification; 11). Arrangement of official minutes of clarification on selection document and its

amendment; 12). submission of proposal; 13). Opening of proposal; 14). Evaluation of the proposal; 15). Decision on the winner; 16). Announcement on the winner; 17). Challenge period; 18). Assignment of the winner; 19). Signing contract;

b. with post qualification: 1). announcement of the bidding; 2). registration to join the bidding; 3). collection of the bidding document; 4). Clarification; 5). Arrangement of official minutes of clarification on selection document and its

amendment; 6). submission of proposal; 7). opening of the proposal; 8). evaluation of proposal including evaluation of qualification; 9). decision on the winner; 10). announcement on the winner; 11). Challenge period; 12). Assignment of the winner; 13). Signing contract;

To the applicant

• *Please describe arrangements for reporting on the progress in implementing and using GAVI HSS funds, including the responsible entity for preparing the APR. (Table 7.5)*

Note: The GAVI Annual Progress Report, due annually on 15 May, should demonstrate: proof of appropriate accountability for use of GAVI HSS funds, financial audit and proper procurement (in line with national regulations or via UNICEF); efficient and effective disbursement (from national to sub-national levels; in the context of a SWAp mechanism, if applicable); and evidence on progress on whether expected annual output targets and longer term outcome targets are being achieved.

7.5: Reporting arrangements

The progress of the project implementation (technical and financial) will be reported by the implementing units quarterly. The GAVI Secretariat CDC will evaluate and compiled the financial and technical reports with inputs from the technical committee. The mechanism will use the monitoring and evaluation process. Based on those data and inputs, the GAVI Secretariat-CDC-MoH will prepare and submit the Country's Annual Progress Report (APR) to the GAVI Alliance Secretariat. The report will contain information on progress in reaching milestones and targets against the baseline data for indicators identified in the application. It will also include the financial report on the utilization of funds. The report will be submitted at 15th May of each year.

The report will be submitted at 15th May of each year

To the applicant

• *Some countries will require technical assistance to implement GAVI HSS support. Please identify what technical assistance will be required during the life of GAVI HSS support, as well as the anticipated source of technical assistance if known (Table 7.6).*

7.6: Technical assistance requirements

Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
18 months	All quarters from 3/2008 to 4/2009	Local university contracted to provide technical assistance to identify parties, design contract, and monitor performance of pilot contracting of NGO provider in Papua
18 months	All quarters from 3/2008 to 4/2009	Local university contracted to manage pilot of incentives for kaders and salaried staff

Section 8: Costs and Funding for GAVI HSS

To the applicant

- *Please calculate the costs of all activities for the duration of the GAVI HSS support. Please add or delete rows / columns to give the right number of objectives, activities and years. (Table 8.1)*

Note: Please ensure that all support costs for management, M&E, and technical assistance are included. Please convert all costs to US$ (at the current exchange rate), and ensure that GAVI deflators are used for future costs (see guidelines on the GAVI website: www.gavialliance.org).

Note: The overall total request for GAVI HSS funds in table 8.1 should not exceed the overall total of GAVI HSS funds allocated in table 8.2. Funds may be requested in annual trenches according to estimated annual activity costs. These may vary annually from the allocation figures in table 8.2.

8.1: Cost of implementing GAVI HSS activities

Area for support	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	**TOTAL COSTS**
	2008…	2008…	2009…	
Activity costs				
Objective 1: Community mobilized to support MCH		***3.665,257***	***6,206,832***	***9,872,089***
Activity 1.1: Assessment and mapping of existing situation relating to community activities in the selected provinces Activity 1.2: Selection of kaders (CHWs) within		1,036,475		1,036,475
their own communities and village level training of kaders using existing training materials Activity 1.3: Development, procurement and		1,014,945	906,356	1,921,301
distribution of IEC materials and equipment including Buku KIA (MCH handbook) Activity 1.4: Sensitization of community and		1,253,836	2,546,164	3,800,000
religious leaders to MCH issues including immunization, and the role of kaders		360,000	371,585	731,585

Activity 1.5: Provision of small grants for the operational costs of community level collective action			2,382,728	2,382,728
Objective 2: Management capacity of MCH personnel improved Activity 2.1: Needs assessment by		***2,626,169***	***7,172,732***	***9,798,902***
MoH/PHO/DHO staff of MCH management issues at district and puskesmas levels Activity 2.2: Advocacy by MoH/PHO staff to district		554,727		554,727
administration and political leaders for adequate budgetary support of MCH activities Activity 2.3: Development and distribution of		205,459	205,459	410,918
management guidelines, tools (such as supervision checklists) and training materials		21,858	664,617	686,475
Activity 2.4: Plan, design and conduct training of District Training Teams who will perform the team training at puskesmas level		707,721	1,415,443	2,123,164
Activity 2.5 Puskesmas team training in micro-planning, supervision, M&E, surveillance and managing community development Activity 2.6: Provision of operational cost to		1,136,404	2,134,557	3,270,962
support implementation of improved management in the topics of the team training **Objective 3:**			2,752,656	2,752,656
Partnerships formed with non-government agencies		***584,180***	***1,681,891***	***2,266,071***

	Activity 3.1: Identification of partners, development of action plans, formulation of MOUs		197,333		197,333	
	Activity 3.2: Strengthening coordination, implementation of MOU, including regular consultations and joint monitoring and evaluation		279,366	732,104	1,011,470	
	Activity 3.3: Engaging private sector partners in MCH service delivery, including orientation to government policies on MCH, and sensitization of TBAs and private midwives		107,481	949,787	1,057,268	
	Objective 4: Operational research on critical barriers performed		***85,246***	***1,103,825***	***1,189,071***	
	Activity 4:1: Pilot project on contracting health service provision for an under-served locality in Papua		42,623	327,869	370,492	
	Activity 4.2 Operational research on incentives for kaders and salaried staff of puskesmas		42,623	775,956	818,579	
	Support costs		**1.000,000**	**701,117**	**1,701,117**	
	Management costs		480,874	357,948	838,822	
	M&E support costs		475,410	261,202	736,612	
	Technical support		43,716	81,967	125,663	
	TOTAL COSTS		**7,960,852**	**16,866,397**	**24,827,250**	

To the applicant • *Please calculate the amount of funds available per year from GAVI for the proposed GAVI HSS activities, based on the annual number of births and GNI per capita[1] as follows (Table 8.2): -If GNI < $365 per capita, country is eligible to receive up to $5 per capita -If GNI > $365 per capita, country is eligible to receive up to $2.5 per capita Note: The following example assumes the birth cohort in the year of GAVI application is 100,000, and gives the total fund allocations if the GNI < $365 per capita and if the GNI > $365 per capita.*

Examples: GAVI HSS country allocation calculation

GAVI HSS Allocation (GNI < $365 per capita)	**Allocation per year (US$)**				
	2007	**2008**	**2009**	**2010**	**TOTAL FUNDS**
Birth cohort	100,000	102,000	104,000	106,000	
Allocation per newborn	$5	$5	$5	$5	
Annual allocation	$500,000	$510,000	$520,000	$530,000	**$2,060,000**

GAVI HSS Allocation (GNI > $365 per capita)	**Allocation per year (US$)**				
	2007	**2008**	**2009**	**2010**	**TOTAL FUNDS**
Birth cohort	100,000	102,000	104,000	106,000	
Allocation per newborn	$2.5	$2.5	$2.5	$2.5	
Annual allocation	$250,000	$255,000	$260,000	$265,000	**$1,030,000**

8.2: Calculation of GAVI HSS country allocation

8.3: Sources of all expected funding for health systems strengthening activities

GAVI HSS Allocation	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	**TOTAL FUNDS**
	2008…	2008…	2009…	
Birth cohort		4930800	5000100	
Allocation per newborn		$2.50	$2.50	
Annual allocation		$12,327,000	$12,500,250	**$24,827,250**

Source and date of GNI and birth cohort information: GNI: World Bank Indonesia Health Public Expenditure Review (forthcoming) (2007)........ Birth cohort: Calculated from Population Reference Bureau data (Total population 2007 231.6m, RNI 1.4% pa, CBR 21/1000).,
.... Total Other:
....

To the applicant*: Note: Table 8.3 is not a compulsory table. • Please endeavour to identify the total amount of all expected health system strengthening related spending in the country during the life of the GAVI HSS application (Table 8.3). Note: Please specify the contributions from the Government, GAVI and the main funding partners or agencies. If there are more than four main contributors, please insert more rows. Please indicate the names of the partners in the table, and group together all remaining expected contributions. Please indicate the source of the data (Public Expenditure Review, MTEF, donor reports etc).*

Funding Sources	Allocation per year (US$)						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	**TOTAL FUNDS**
	20…	20…	20…	20…	20…	20…	
GAVI							
Government							
Donor 1.							
Donor 2.							
Donor 3.							
Donor 4.							
Total Other							
TOTAL FUNDING							

Source of information on funding sources: GAVI:

.... Government:

.... Donor 1:

.... Donor 2:

.... Donor 3:

.... Total other:

....

Section 9: Endorsement of the App

To the applicant:

- *Representatives of the Ministry of He*
  Sector Coordinating Committee (HSC
- *All HSCC members should sign the*
  was endorsed. This should be submit
- *Please give the name and contact de*

Note: The signature of HSCC members
provided in this application, as well as th
imply any financial or legal commitment c

9.1: Government endorsement

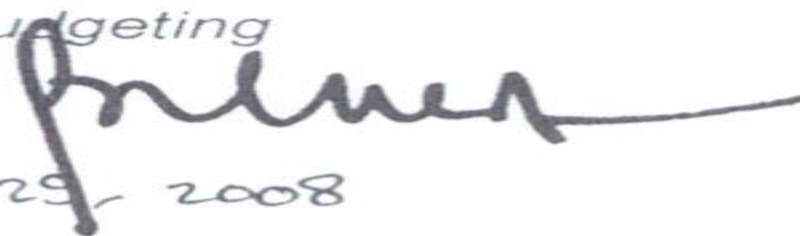
The Government of the Republic of Indo
child and maternal health services on a
systems will be reviewed annually thro
requests that the GAVI Alliance funding
strengthening of health systems as outlin

Ministry of Health:

Name : Dr. Budihardja, DTM&H, MPH

Title / Post: Head, Bureau of Planning
Budgeting

Signature:



Date: Feb 29, 2008

9.2: Endorsement by Health Sector Coo

Members of the Health Sector Coordinatio
meeting on 29 February 2008. The signed

Chair of HSCC:

Name: DR. Arum Atmawikarta, MPH

Signature:

9.3: Person to contact in case of enqui

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

To the applicant:

- *Please number and list in the table below all the documents submitted with this application.*

Note: All supporting documentation should be available in English or French, as electronic copies wherever possible. Only documents specifically referred to in the application should be submitted.

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Sector Strategic Plan (or equivalent)	Yes	2004-2009	1
cMYP[7]	Yes	2007-2011	2
MTEF[8]	No		
PRSP[8]	No		
Recent Health Sector Assessment documents	Yes	Various dates	3
HSCC minutes, signed by Chair of HSCC	Yes	2007 – 2008	4

7 If available – and if not, the National Immunisation Plan plus Financial Sustainability Plan [8] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application