

**INDONESIA EMERGENCY RESPONSE TO COVID-19 ADDITIONAL
FINANCING (P175759) PROGRAM FOR RESULTS**

**ADDENDUM TO THE ENVIRONMENTAL AND SOCIAL SYSTEMS
ASSESSMENT – DRAFT REPORT
(ESSA)**

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Disclaimer: This document is a draft and the information contained herein is subject to change as this document is currently being finalized.

ABBREVIATIONS AND GLOSSARY

TERM	EXPANDED TERM/ DEFINITION
AIIB	Asian Infrastructure Investment Bank
AF	Additional Financing
BBTKLPP	Environmental Health and Disease Control Centre or <i>Balai Besar Teknik Kesehatan Lingkungan Dan Pengendalian Penyakit</i>
BNPB	National Disaster Management Authority or <i>Badan Nasional Penanggulangan Bencana</i>
BPJS	National Social Health Insurance Agency or <i>Badan Penyelenggara Jaminan Sosial</i>
BPKP	Finance and Development Monitoring Agency
BPOM	National Agency for Drugs and Food or <i>Badan Pengawas Obat dan Makanan</i>
BSSN	State Cyber and Code Agency or <i>Badan Siber dan Sandi Negara</i>
CCE	Cold Chain Equipment
CDC	U.S. Centre for Disease Control
CHAI	Clinton Health Access Initiative
CISDI	Center for Indonesia's Strategic Development Initiatives (CISDI)
COVAX	COVID-19 Vaccines Global Access Facility
COVID-19	Coronavirus Disease 2019
DFAT	Australia's Department of Foreign Affairs and Trade
DG	Director General
DLI	Disbursement Linked Indicator
DTKS	Database for Social Protection or <i>Data Terpadu Kesejahteraan Sosial</i>
E&S	Environment and Social
ESFT	Essential Supplies Forecasting Tool
ESSA	Environmental and Social Systems Assessment
EUA	Emergency use Authorization
<i>Fasyankes</i>	<i>Fasilitas Pelayanan Kesehatan</i>
FGRM	Feedback and Grievance Redress Mechanism
GAVI	Global Alliance for Vaccine and Immunization
GDPR	General Data Protection and Regulation
GIIP	Good International Industry Practice
GOI	Government of Indonesia
GPS	Global Positioning System
GRS	Grievance Redress System
HCF	Health Care Facilities
HRH	Health Care Resources
IBRD	The International Bank for Reconstruction and Development
IPC	Infection Prevention and Control
I-SPHERE	Indonesia – Supporting Primary Health Care Reform
ITAGI	Indonesia Technical Advisory Group on Immunization
JKN	National Health Insurance Program or <i>Jaminan Kesehatan Nasional</i>
KARS	Hospital Accreditation Commission or <i>Komisi Akreditasi Rumah Sakit</i>
KIPI	Immunization side effects or <i>Kejadian Ikutan Paska Imunisasi</i>
KKI	Indonesian Medical Council or <i>Komite Kesehatan Indonesia</i>
KPCPEN	Committee for Handling COVID-19 and National Economic Recovery or <i>Komite Penanganan COVID-19 dan Pemulihan Ekonomi Nasional</i>
KNKP	National Commission for Patient Safety or <i>Komite Nasional untuk Keselamatan Pasien</i>
KTKI	Council of Health Human Resource or <i>Komisi Tenaga Kesehatan Indonesia</i>
KTP	Civil ID Card <i>Kartu Tanda Penduduk</i>
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersexed
MENKES	Ministry of Health or <i>Kementerian Kesehatan</i> (same as MOH)
MKDKI	Indonesian Medical Disciplinary Board or <i>Majelis Kehormatan Disiplin Kedokteran Indonesia</i>
MOEF	Ministry of Environment and Forestry
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs

MTR	Mid-Term Review
mRNA	Messenger Ribonucleic acid
MUI	Indonesia Ulema Council or <i>Majelis Ulama Indonesia</i>
NCD	Non-communicable Disease
NGO	Non-Governmental Organisation
NIHRD	National Institute for Health Research and Development
NIK	Civil Registration Number or <i>Nomor Induk Kependudukan</i>
OHS	Occupational Health and Safety
P-Care	Primary Care Application
PAP	Program Action Plan
PCR	Polymerase Chain Reaction
PDO	Program Development Objective
<i>Permen</i>	Ministerial Regulation
<i>Perpres</i>	Presidential Regulation
PPSDM	Planning and Empowerment of Human Resource for Health or <i>Badan Pengembangan dan Pernerdayaan Sumber Daya Manusia Kesehatan</i>
PforR	Program-for-Results
<i>Polindes</i>	Village level delivery posts or <i>Pondok bersalin desa</i>
<i>Posyandu</i>	Village health posts
<i>PP</i>	Government Regulation or <i>PP</i>
PPE	Personal Protective Equipment
<i>Pusdatin</i>	Center for Health Data and Information or <i>Pusat data dan informasi</i>
<i>Puskesmas</i>	Public Primary Health Center
<i>Pustu</i>	Auxiliary <i>puskesmas</i>
RA	Result Area
<i>Renstra</i>	Health Strategic Plan or <i>Rencana Strategis</i>
<i>Rorenggar</i>	Bureau of Planning and Budgeting
SAGE	Strategic Advisory Group of Experts on Immunization
<i>SIAK</i>	Population Administration Information System or <i>Sistem Informasi Administrasi Kependudukan</i>
<i>SISDMK</i>	Information System on Health Human Resources or <i>Sistem Informasi Sumber Daya Manusia Kesehatan</i>
<i>SMILE</i>	Immunization and Logistic Electronic Monitoring System or <i>Sistem Monitoring Imunisasi dan Logistik Secara Elektronik</i>
SMS	Short Message Service
<i>SNARS</i>	National Hospital Accreditation Standard or <i>Standard Nasional Akreditasi Rumah Sakit</i>
SOE	State-Owned Enterprise
SOP	Standard Operating Procedure
SRA	Stringent Regulatory Authorities
SUSENAS	The National Socioeconomic Survey or <i>Survey Sosial Ekonomi Nasional</i>
UNICEF	United Nations Children's Fund
USAID	The United States Agency for International Development
VRAF	Vaccine Readiness Assessment Framework
VRAT	Vaccine Introduction Readiness Assessment Tool
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization

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DRAFT VERSION

EXECUTIVE SUMMARY

1. An Additional Financing (AF) to the on-going Indonesia Emergency Response to COVID-19 Program (P173843) is being prepared to support the Government of Indonesia (GoI) in its efforts to enable affordable and equitable access to vaccines across the country. The Program Development Objective (PDO) of the AF remain unchanged – “to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia”. The Ministry of Health (MOH) remains the implementing agency of the program, with slight adjustment to include Ministry of Health’s immunization sub-directorate. The overall coordination responsibility remains with the Secretary General’s Bureau of Planning and Budgeting.
2. The program boundary has increased at MTR, fueled by the rising number of COVID-19 cases and rising budget needs for detection and treatment. In addition, the program boundary has been further augmented during this AF to accommodate:
 - a. Continuation of the existing response in 2021 through additional budget already allocated for the MOH. This includes for COVID-19 patients treatment, incentives and compensation to human resources in the health sector, and testing supplies, PPE and critical care related equipment.
 - b. Health system preparedness for COVID-19 vaccination for COVID-19 vaccination such as developing policy frameworks for the safe and effective deployment of COVID vaccines.
 - c. Safe and effective deployment of COVID-19 vaccines by supporting strengthened planning processes to establish guidelines and institutional frameworks and thereafter support the GOI programs to bring immunization systems and service delivery capacity to the level required to successfully deliver COVID-19 vaccines at scale.
3. The PforR is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities or cold-chain infrastructure. The PforR Program does not require infrastructure investments for the achievement of the PDO and/or Disbursement Linked Indicators (DLIs).
4. The scope of the ESSA addendum covers a) implementation progress of the environmental and social plans as recommended through the original ESSA, b) assessment of system capacities within implementing agencies for additional activities included in the AF. Environmental and social aspects, defined as areas of concerns, reviewed as part of this ESSA addendum cover a) population targeting, social inclusion and equity; b) public health communication and stakeholder engagement; c) individual rights to vaccination and consent, particularly amongst population groups who are sceptical and/or refuse vaccination; d) handling of grievances, including pharmacovigilance measures to monitor adverse events; e) individual data privacy; e) environmental pollution and community health and safety issue related to the handling, transportation and disposal of COVID-19 vaccine wastes (i.e. syringes, vials, PPEs, etc.); f) vaccine safety related to end-to-end supply chain and logistics management systems for effective vaccine storage, handling, and stock management – including rigorous cold chain control; g) Occupational Health and Safety (OHS). These areas of concern are aligned with the World Bank’s Vaccine Readiness Assessment Framework (VRAF).
5. Similar to its parent PforR, the environmental and social risk is deemed to be substantial. There is a likelihood the Program would lead to some E&S consequences, but the risks are predictable and can be managed through risk management measures. The current strain capacity of MOH in responding to the pandemic may contribute to the possibility of the program may not achieve its E&S operational objectives or sustain the desired E&S results.
6. GoI’s COVID-19 vaccine program aims to provide free vaccines to its entire adult population, or 181.5 million people, recognizing such vaccination as key to reducing morbidity and mortality, as well as for economic recovery from the pandemic. This makes Indonesia a frontrunner among middle income

countries of its size, in committing to free access to COVID-19 vaccines for everyone. GOI's prioritization criteria are generally aligned with the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and Indonesian Technical Advisory Group on Immunization (ITAGI). COVID-19 vaccination seeks to focus on reduction of direct morbidity and mortality and maintenance of most critical services, while considering reciprocity towards groups that have been placed at disproportionate risks to mitigate consequences of this pandemic (i.e. frontline health workers). There are about 181.5 million people to be vaccinated (or 67 percent of the population), requiring 426 million doses of vaccines with a double-dose regimen and assuming 15 percent wastage. The GOI's adoption of the SAGE/ITAGI recommendation to include the elderly (above 59 years old) in the national vaccination program has been supported with the confirmation of vaccine efficacy and safety from the Indonesian regulatory authority, BPOM (National Food and Drug Control Agency) and vaccination for those over 60 years of age has commenced in February 2021.

7. While it is acknowledged that under the pandemic situation the GoI will need to thread and balance carefully the human wellbeing objective (of reducing COVID 19-related deaths and morbidity) and the objective of economic recovery especially in making decisions about prioritized groups, there are concerns that the government may focus on economic recovery more than public health goal. There may be trade-off but there are also ways to reconcile the two objectives. Prioritizing healthcare workers, essential sectors, elderly and vulnerable populations may help to reduce the number of deaths and severe illnesses, to ease the strain on the health system, and at the same time contribute to economic recovery.
8. The Presidential Regulation no. 14/2021 on COVID-19 vaccination introduces administrative sanctions for refusal of vaccination. However, whether and how sanctions will be enforceable is unclear and is a matter of debate since there are no guidelines and/or operational manuals to enact relevant provisions on sanctions in the regulation. Under this PforR, public health communication for COVID-19 vaccination should emphasize persuasion. A legal covenant has been agreed to ensure that the GOI carries out the Program in conformity with, *inter alia*, best practices in public vaccination. Provisions for medical exemptions are also already included in the technical guidelines of the MOH, which also forms part of the screening by health workers prior to each vaccination.
9. Disparity between hazardous medical waste volume and the processing capacity remains the biggest challenge in managing COVID-19 related wastes in Indonesia, especially in the regions outside Java. More than half of licensed medical waste processing facilities and transporters are located in the island. It is expected that additional medical waste generated from COVID-19 vaccination activities may add more burden to the now-strained medical waste management system. MOH and MOEF have conducted various efforts in improving medical waste management in the country, these include distributing and constructing additional medical waste processing equipment, developing and disseminating COVID-19 waste management guidelines, and conducting training and webinar for healthcare workers and local environment/health agencies. Additional guidance on management of waste during vaccination activities is already included in the recently published vaccination technical guideline. Continuous interagency cooperation in addressing concerns related to medical waste management and its supervision remains critical in ensuring the proper implementation of relevant regulations and guidelines.
10. There is a risk of COVID-19 exposure to healthcare workers during vaccination activities. Specific measures pertaining to OHS requirements during vaccine administration are included in the MOH's technical guideline for COVID-19 vaccination. The measures include a) priority vaccination for those administering vaccination, including supporting personnel; b) application of health and basic hygiene protocols, and use of PPEs, c) social distancing requirements, d) fatigue management by capping daily quotas. Additional PPE supplies for healthcare workers and other personnel involved in the vaccination program is also needed. Logistical planning for vaccination, which consider the needs to assess and procure PPEs, is also prescribed in MOH's technical guideline. A system to monitor the distribution of vaccines and other logistics, including PPEs, have been developed. The implementation of this monitoring system is critical to ensuring healthcare workers are properly equipped with PPE so as to minimize exposure risk. Prioritizing healthcare workers to receive the vaccines is expected to provide

infection protection to these workers as frontliners. Over 93% of all health workers are now fully vaccinated (a large proportion of the remaining health workers are believed to have been exempted due to medical reasons).

11. People in remote areas, including vulnerable groups such as Indigenous Peoples and marginalized groups such as people with disabilities, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTQI) persons, religious minorities may face constraints in accessing COVID-19 vaccines despite their willingness to be vaccinated. The assessment acknowledges that access equity remains low, with disparities in geographical access, health worker distribution, and quality of services, particularly in Eastern Indonesia. People who are not part of any government's registries or whose domicile do not match their administrative records may be excluded. This population may include, but not limited to, circular or seasonal migrants, homeless people and street children, transgender population, and isolated populations. There are risks for individuals without Single Identity Numbers (*Nomor Induk Kependudukan* or hereafter NIK) may potentially be excluded with a new requirement for NIK as an eligibility criterion which has been required by the anti-corruption commission for accountability of vaccine usage. As the transmission is disproportionately high in urban areas, certain urban populations might also be inadvertently excluded from targeting and identification due to mismatch between their actual residential address and their administrative records. They include people living in informal settlements, newly arrived migrants who have not updated their administrative record, as well as seasonal and transient migrants (including migrant students). Measures to address exclusion errors through bottom-up processes are therefore critical understanding that there are likely loop holes in the existing One Data Information System for COVID-19 Vaccination. Such measures will need to be inclusive, responsive and agile to inform vaccination planning due to limited availability of vaccines in the near and medium-term.
12. Gender inequalities may likely exacerbate access to vaccination. These may stem from access issues (i.e. access to information, services, and trade-offs with domestic responsibilities) as well as socio-cultural barriers where men may get prioritization. Further, since pregnant women are not eligible for vaccination, it is not clear with regards to their access following labor and/or whether there will be prioritization for women who expect pregnancy prior to vaccination. Women-friendly and safe spaces for vaccine delivery are also an important element to ensure well-being of women during vaccination. Understanding that COVID-19 vaccination may take up precious health resources, which are already strained particularly in lagging regions, there are risks that such a program may disrupt the regular maternal health services, including ante- and post-natal care. Under the PforR, measures to promote accessibility and availability of non-COVID-19 essential health services have been agreed with MOH.
13. A guideline for personal data protection for the purpose of COVID-19 vaccination has been developed by the MOH's Center of Data and Information. The guideline needs to be further operationalized to include relevant measures in the event of breach, violation to the integrity pacts, and data leakages. Under this PforR, the extent of personal data being shared and collected throughout the vaccination process should adhere to the minimum standard and purposive limitation of individual data privacy in line with the General Data Protection and Regulation (GDPR), which is the main reference for the Personal Data Protection Bill. No information irrelevant to the vaccination program could be shared and/or collected. The development and use of the population database registry should only be used for vaccination purposes and individual privacy should be protected. Individual identifying data should only be accessible to officials and workers associated with the implementation of vaccination and should not be shared with other parties without consent from authorities.
14. The proposed environmental and social action plans under the AF correspond to relevant risks considered within the scope of the ESSA (refer Section E). The focus will be on enhancing the capacity of the MOH as the implementing agency to provide technical guidance, oversight, and capacity building for environmental and social risks, particularly on aspects related to population targeting, social inclusion and equity; public health communication strategy and stakeholder engagement; individual rights to vaccination and consent; handling of grievances; individual data privacy particularly with regards to individual targeting and tracing; handling of hazardous medical wastes from vaccination

activities; OHS and working conditions associated with the transportation, distribution and administration of vaccines and; community health and safety associated with vaccine quality and end-to-end supply chain and logistics management systems.

15. Due to COVID-19 travel restrictions, virtual consultations for the AF preparation have been held in order to overcome limitations on the level of proposed direct engagement with stakeholders. With a recent increase in cases in the country, populations have been advised and mandated by law to exercise social distancing and specifically to avoid public gatherings to prevent and reduce the risk of virus transmission. The initial draft ESSA addendum has been disclosed prior to appraisal, prior to consultations with MOH and other stakeholders on the assessment and environment and social action plans. The final document will be disclosed prior to Board approval, capturing all agreed actions and relevant time-bound achievement indicators.
16. Communities and individuals who believe that they are adversely affected as a result of a World Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit <http://www.inspectionpanel.org>.

A BACKGROUND AND SCOPE

A.1 Program Description

17. An Additional Financing (AF) to the on-going under the Indonesia Emergency Response to COVID-19 Program (P173843), hereinafter referred to as the Program, is being proposed to support the Government of Indonesia (GoI) in its efforts to enable affordable and equitable access to vaccines across the country. The primary objectives of the AF are to further strengthen preparedness and response activities under the parent program and enable affordable and equitable access to COVID-19 vaccines. Given the importance of limiting the spread of COVID-19 for both health and for economic recovery, providing access to COVID-19 vaccines will be critical to improve health outcomes as well as to accelerate economic and social recovery.
18. The parent PforR, Indonesia - Emergency Response to COVID-19, was approved on May 22, 2020. The Program development objective (PDO) of the parent Program (which remains unchanged for the proposed AF) is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia. Parent program includes three results areas:
 - Results area 1 addresses hospital and health system readiness and systemic improvements in the quality of care;
 - Results area 2 strengthens the GOI's public health laboratory and surveillance systems;
 - Results area 3 facilitates communication and coordination for better pandemic response and preparedness.
19. The proposed AF and restructuring will finance the scale-up of Program activities and new activities that will focus on results to achieve the PDO and enhance the impact of the parent COVID-19 PforR. The existing PDO level indicators also remains unchanged, however, the target values will be updated to account for the current achievements and extended duration of the program. An additional PDO level outcome indicator will be added, on *Number of persons who have received free vaccination in accordance with the prioritization plan*. The summary of DLIs for the AF is presented in **Annex 1**. The duration of the Program would be extended from October 31, 2021 to December 31, 2022 to align with the proposed closing date of the AF loan.

A.2 Program Boundary and Activities

20. Two schemes of COVID-19 vaccination are being contemplated, including the government and private. The predominant national scheme, which is supported by this Program, will be implemented by MOH and free of charge. The second scheme aimed at private employers to provide free vaccination to their employees will be led by the Ministry of State-Owned Enterprises, in partnership with MOH. The AF Program concerns with the government vaccination program.
21. The Program boundaries are aligned with the Government program, except that the Program will not finance the procurement of COVID-19 vaccines. The PforR instrument, used for the Program financing is not considered suitable to undertake the needed high-value procurement of COVID-19 vaccines, according to the World Bank guidance on processing vaccine operations. The Program will support strengthening health and vaccine deployment system in the country, including costs for consumables such as PPEs, strengthening the cold chain system, supporting operational costs of the MOH vertical hospitals, and scaling up the current response. No new construction is envisaged with this financing.
22. The AF focuses on the immediate health sector needs and represents a sub-set of the overall GoI's emergency response to the COVID-19 outbreak. Total IBRD financing is US\$750 million including US\$250 million of the original financing and US\$500 million from this AF. Co-financing for the AF includes Asian Infrastructure Investment Bank (AIIB) at US\$500 million, Kreditanstalt fur

Wiederaufbau (KfW) at US\$ 235 million, and a grant of US\$ 9.9 million from Government of Australia. The AF envelope covers the costs of strengthening the country's health system to deliver the COVID-19 vaccine safely and effectively to the target beneficiaries, scaling up the country's capacity in its response to the pandemic, and maintaining the delivery of non-COVID essential services.

23. The program boundary has increased at MTR, fueled by the rising number of COVID-19 cases and rising budget needs for detection and treatment. In addition, the program boundary will be further augmented during this AF to accommodate:
- a. **Continuation of the existing response in 2021** through additional budget already allocated for the MOH. This includes continued costs of COVID-19 response in the 2021 budget and line items for treatment of COVID-19 patients; incentives and compensation to human resources (HR) in the health sector for the extended period of response; and continued needs for testing supplies, PPE, and oxygen-related equipment and other line items related to the Program DLIs, as were also included in the Program boundaries for the original financing based on the 2020 budget. Accounting data on actual budget realization for 2020 have just been received, and the original boundary for 2020 will also stand updated to reflect the actual spending in 2020.
 - b. **Health system preparedness for COVID-19 vaccination** such as developing policy frameworks for the safe and effective deployment of COVID-19 vaccines. This includes the establishment of policies related to best practice in vaccination; a fair and documented basis for prioritizing intra-country vaccine allocation; systems for reporting any adverse events; and the creation of accountability, grievances, and citizen and community engagement mechanisms.
 - c. **Safe and effective deployment of COVID-19 vaccines** by supporting strengthened planning processes to establish guidelines and institutional frameworks and thereafter support the GOI programs to bring immunization systems and service delivery capacity to the level required to successfully deliver COVID-19 vaccines at scale.

The program boundaries will also be extended to cover primary care healthcare facilities (or hereafter *Puskemas*) as most of immunization services are held in these facilities.

24. The proposed AF supports the GOI in strengthening institutional readiness for the country's COVID-19 vaccines rollout to augment its COVID-19 response. The proposed AF supports Indonesia's planning processes to establish guidelines and institutional frameworks for safe and effective deployment of the eligible vaccines. These include:
- a. Development of policies for prioritizing intra-country vaccine allocations following principles established in the WHO Fair Allocation Framework;
 - b. Establishment of a pharmacovigilance system to report adverse events on time;
 - c. Planning to address gaps in supply chain and logistics to maintain cold chain;
 - d. Development of a communications strategy, based on a continuous and reliable assessment of vaccine hesitancy and mitigation measures planned to improve uptake and that adequately accommodates cultural sensitivity, as well as a consultative and transparent process for decision-making on vaccine prioritization and deployment; and
 - e. The creation of accountability, grievances, and citizen and community engagement mechanisms.
25. Given the complexity of COVID-19 vaccine deployment and system strengthening for the rollout, technical assistance closely linked to Program activities is also planned to be provided from the World Bank and its co-financing partners. This technical assistance will include support from necessary global and national expertise in implementing the COVID-19 response and vaccination program, and also support subnational authorities in effective implementation of the program. A related endeavor will be to minimize unintended consequences of the COVID-19 vaccination and

response on the overall health system performance. A key objective will be to ensure that essential, non-COVID-19 services are not disrupted by the mass vaccination efforts being added on top of a stretched health system already burdened with a continued and prolonged COVID-19 response while also grappling with subdued demand due to mobility restrictions and delays in seeking health care due to perceived risk of exposure to infection.

26. The PforR Program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities or cold-chain infrastructures. The PforR Program does not require infrastructure investments for the achievement of the PDO and/or DLIs.
27. The Ministry of Health (MOH) is the implementing agency of the program, with multiple implementing units responsible for different disbursement-linked indicators (DLIs), including the Director General of Health Services, Disease Control, and the Institute of Research and Development. The implementation arrangements would have to be slightly adjusted to include Ministry of Health's immunization sub-directorate. The overall coordination responsibility remains with the Secretary General's Bureau of Planning and Budgeting.

A.3 Scope of the ESSA Addendum

28. This document is an addendum to the ESSA for the Indonesia – Emergency Financing Support for COVID-19 Program-for-Results (PforR – P173843). The scope of the ESSA addendum covers on a) implementation progress of the environmental and social plans as recommended through the original ESSA, b) assess system capacities within implementing agencies for additional activities included in the AF.
29. The addendum is being prepared to serve the following objectives:
 - to assess existing environmental and social capacities within implementing agencies and whether there have been improvements since the preparation of the parent PforR;
 - to identify relevant legislative and procedural changes since the preparation of the parent PforR and how these may impact on the PforR implementation (both the parent Program and AF);
 - to identify new potential environmental and social risks from the AF and;
 - to recommend additional measures to further strengthen the environmental and social system under the AF.
30. Similar to its parent PforR, the environmental and social risk is deemed to be **substantial**. There is a likelihood the Program would lead to some E&S consequences, but the risks are predictable and can be managed through risk management measures. The current strain capacity of MOH in responding to the pandemic may contribute to the possibility of the program may not achieve its E&S operational objectives or sustain the desired E&S results. Further elaboration on the rating is presented in **Section F**.
31. Environmental and social aspects, defined as areas of concerns, reviewed as part of this ESSA addendum cover a) population targeting, social inclusion and equity; b) public health communication and stakeholder engagement; c) individual rights to vaccination and consent, particularly amongst population groups who are sceptical and/or refuse vaccination; d) handling of grievances, including pharmacovigilance measures to monitor adverse events; e) individual data privacy; e) environmental pollution and community health and safety issue related to the handling, transportation and disposal of COVID-19 vaccine wastes (i.e. syringes, vials, PPEs, etc.); f) vaccine safety related to end-to-end supply chain and logistics management systems for effective vaccine storage, handling, and stock management – including rigorous cold chain control; g) Occupational Health and Safety (OHS), particularly for health workers and personnel administering vaccination.

These areas of concern are aligned with the Vaccine Introduction Readiness Assessment Tool (VIRAT)/Vaccine Readiness Assessment Framework (VRAF) recommended by the World Bank, WHO and UNICEF.

A.4 Approach to the ESSA

- 32.** An environmental and social risk screening for the AF was undertaken at the concept stage (refer to Annex 4). The purpose of the screening is two-pronged. First, the screening is to confirm that there are no activities which meet the defined exclusion criteria included in the PforR in line with the Bank Guideline for the ESSA. Secondly, the screening established the initial scope of the ESSA addendum. This includes the identification of relevant systems and sub-systems under the PforR and relevant stakeholders for engagement and consultations both within MOH and external parties.
- 33.** The ESSA addendum process was informed by the Bank Guidance on PforR Environmental and Social System Assessment (June 28, 2019). The guidance sets out core principles and planning elements used to ensure that PforR operations are designed and implemented in a manner that maximizes potential environmental and social benefits while avoiding, minimizing or mitigating environmental and social harm.
- 34.** Following the initial screening, the system review was conducted using a two-step approach:
 - a. Identification of relevant systems that are pertinent to the AF will be addressed in Section C on Review of Policy, Regulatory, and Institutional Frameworks; and
 - b. Analysis of the implementation of the systems, including capacity and enforcement of certain environmental and social measures, to respond to COVID-19 crisis will be addressed in Section D.
- 35.** An assessment of the adequacy of MOH's operating framework in the management of environmental and social risks under the AF stocktaked on the assessment findings produced by MOH using the Vaccine Introduction Readiness Assessment Tool (VIRAT), developed by the World Health Organization (WHO) and United Nations Children's Fund (UNICEF), which was subsequently integrated with the World Bank's Vaccine Readiness Assessment Framework (VRAF). This was supplemented, where relevant, with reference to Good International Industry Practices (GIIP) guidelines including:
 - a. WBG ESH guidelines on/for (i) health care facilities; (ii) waste management (iii) community health and safety;
 - b. Center for Disease Control and Prevention (CDC) COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operation¹ and;
 - c. WHO guidelines on (i) values framework for the allocation and prioritization of COVID-19 vaccination (prepared jointly with the Strategic Advisory Group of Experts on Immunization (SAGE²); (ii) Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply³, (iii) Interim Guidance on Immunization Services during COVID-19⁴, (iv) Management of Waste from Immunization Campaign Activities⁵, (iv) WHO's Interim Guideline on Health Workforce Policy and Management in the Context of the COVID-19 Pandemic Response⁶, (v) Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response⁷, (vi) WHO Vaccine Safety Events:

¹ Version 2.0 issued on 29 October 2020

² Issued on 13 September 2020

³ Issued on 3 September 2020

⁴ Issued on 26 March 2020

⁵ Issued in 2006

⁶ Issued on 3 December 2020

⁷ Issued on 16 March 2020

Managing the Communications Response⁸, (vii) Safe Management of Waste from Health-care Facilities⁹, (viii) Technical Brief on Water, Sanitation, Hygiene and Waste Management for COVID-19¹⁰, (ix) Rational Use of Personal Protective Equipment for COVID-19¹¹, (x) developing a national deployment and vaccination plan for COVID-19 vaccines¹², (xi) How to Monitor Temperatures in the Vaccine Supply Chain¹³, (xiii) Aide-memoire: Infection Prevention and Control (IPC) principles and procedure for COVID-19 vaccination activities¹⁴, (xiv) WHO COVID-19 Vaccines : Safety Surveillance Manual¹⁵

- 36.** Similar to the parent PforR, there is no single system under the ESSA. The AF is built on multiple MOH's interventions to roll-out COVID-19 vaccination and its associated activities, including distribution and monitoring. Various systems were assessed as part of the ESSA addendum, depending on how such systems are relevant to the management of potential environmental and social risks and impacts. The assessment of the MOH's systems for the management of environmental and social aspects considers relevant elements within the existing broader systems and selection was based on the level of potential environmental risks and impacts as well as social considerations. The assessment focuses on the adequacy of the relevant systems, including implementation, and MOH's capacity to provide technical guidance, enforcement, and audit at the facility level.
- 37.** The ESSA addendum enabled the identification of gaps in the documented systems and their implementation, enabling the development of specific actions for improving environmental and social performance (Section E) under the Program. The actions outline measures to address environmental and social risks and impacts, when the actions are considered complete, as well as the timeframe, responsibility and resource requirements.

⁸ Issued in 2013

⁹ 2nd edition, issued in 2014

¹⁰ Issued on 3 March 2020

¹¹ Issued on 27 February 2020

¹² Issued on 16 November 2020

¹³ Issued on July 2015

¹⁴ Issued on 15 January 2021

¹⁵ <https://apps.who.int/iris/handle/10665/338400>; Published January 2021

B STAKEHOLDER ENGAGEMENT

38. This section provides a summary of the engagement activities undertaken for the PforR and specifically for the ESSA addendum, as well as future engagement activities for ESSA addendum disclosure. Stakeholder engagement will form part of the PforR implementation, particularly in multi-sectoral coordination and planning for COVID-19 vaccination, which requires a robust public health communication strategy and implementation, involving both government and non-government stakeholders at the national and sub-national levels, line ministries/agencies, sub-national governments, media, civil society organizations and communities at large.
39. Due to COVID-19 travel restrictions, virtual consultations have been held in order to overcome limitations on the level of proposed direct engagement with stakeholders. A series of consultations with MOH took place during the course of AF preparation, with external consultations being undertaken on 24th of November, 2020, 26th of November 2020, 10th May 2021, and 18th May 2021. With a recent increase in cases in the country, populations have been advised and mandated by law to exercise social distancing and specifically to avoid public gatherings to prevent and reduce the risk of virus transmission. Consultations and stakeholder feedback are an integral part of Bank operations and so rather than defer stakeholder engagement, virtual consultations have been designed to be fit for purpose.
40. Stakeholder groups consulted included relevant agencies within MOH, sub-national governments, civil society and non-government representatives and representatives relevant to the COVID-19 vaccination program. Stakeholder consultations will continue prior to the closing of the appraisal. Details of the stakeholders consulted as part of the preparation are presented in **Table 1**, with minutes of consultations being appended in **Annex 6**.

Table 1: Stakeholders Consulted in the Preparation of the Program.

Stakeholder Group	Stakeholders
Government Stakeholders	
Central Government	Ministry of Health <ul style="list-style-type: none"> - Bureau of Planning - DG of Pharmaceutical Services for Medical Supplies - Directorate of Referral Services - Directorate of Primary Health Services - Bureau of Communication and Public Services - Directorate of Surveillance and Health Quarantine - Sub-directorate of Immunization - Directorate of Health Promotion - Directorate of Occupational Health and Safety - Secretary of the Board for Planning and Empowerment of Human Resource for Health - The National Institute for Health Research and Development, especially the Center for Biomedics and Health Technology
Sub-national government	<ul style="list-style-type: none"> - Provincial Health Office of DKI Jakarta - Association of Sub-national Health Offices – <i>to be consulted</i>
Non-Government Stakeholders	
NGOs and CBOs	<ul style="list-style-type: none"> - HIVOS, GWL-INA, KEBAYA, YSSfor LGBTQI - Rumah Cemara, Persaudaraan Korban NAPZA - OPSI for sex workers - IPPI, JIP for PLHIV

Stakeholder Group	Stakeholders
	<ul style="list-style-type: none"> - Rujak Center for Urban Studies (RCUS) - Indonesia TB Survivor Organization Association (<i>Perhimpunan Organisasi Pasien TB Indonesia</i>) – <i>to be consulted</i> - The Alliance of Indigenous Peoples of the Archipelago (AMAN) - Nexus3 Foundation - <i>Yaksa Pelestari Bumi Berkelanjutan</i> (YPBB) Bandung - Greeneration Foundation & Waste4Change - PKBI Foundation
Think Tank Group and Watchdog	<ul style="list-style-type: none"> - Center for Indonesia's Strategic Development Initiatives (CISDI) - Center of Epidemiological and Surveillance Research, University of Indonesia - The National Commission on Violence Against Women (KOMNAS Perempuan) - Center on Child Protection and Wellbeing (PUSKAPA) - Kawal COVID-19
Association/private sector	<ul style="list-style-type: none"> - Health Professional Associations - Association of Private Health Facilities (ARSSI) – <i>to be consulted</i>
Development partners	<ul style="list-style-type: none"> - World Health Organization (WHO) - United Nations Children's Fund (UNICEF) - United Nations Development Program (UNDP) - The United States Agency for International Development (USAID) - Australia's Department of Foreign Affairs and Trade (DFAT) - Asian Infrastructure Investment Bank (AIIB) - Kreditanstalt für Wiederaufbau (KfW)
Health Facilities and Laboratories	
Referral Hospitals	<ul style="list-style-type: none"> - Hospital associations – <i>to be consulted</i>
Laboratories	<ul style="list-style-type: none"> - Eijkman Institute – <i>to be consulted</i>
Puskesmas	<ul style="list-style-type: none"> - FKTP associations – <i>to be consulted</i>

41. Due to engagement limitations during the ESSA preparation, views of vulnerable groups were sought through engagement with advocacy groups and civil society organizations. Community views will be captured as part of the PforR implementation, particularly through the Program's efforts to strengthen public communication, community outreach and social inclusion measures. Vulnerable groups considered under the Program include poor households, people with comorbidities, transient or circular migrants, children and people with disabilities, and marginalized groups, including LGBTQI individuals as well as religious and ethnic minorities. Due to their respective circumstances, these groups may face access barriers to vaccination and/or receiving adequate information about the Program.

42. Stakeholder consultations and engagement will continue as part of the AF implementation. As there were engagement limitations during the preparation, environmental and social actions recommended through the ESSA addendum will be consulted continuously to relevant stakeholders during the Program implementation, including on thematic issues where resolution requires inter-agency collaboration and consensus. The initial draft ESSA addendum has been disclosed prior to appraisal and the final version will be disclosed prior to the Board approval.

C POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORK

43. This section provides an overview of legal and regulatory frameworks applicable for COVID-19 vaccination. An earlier legal and regulatory undertaken under the parent PforR (P173843) **remains valid**. Key policy and regulatory frameworks assessed include relevant policy and regulatory frameworks for COVID-19 vaccination, including review of COVID-19 vaccination guideline (to be issued by MOH). Sectoral regulations relevant for environmental and social management were reviewed as part of the parent ESSA. The addendum includes additional regulatory review relevant to the activities supported by the AF and regulatory amendment that has been undertaken since the publication of the parent ESSA.

C.1 Policy, Legal and Regulatory Framework

44. The overarching legal frameworks for the handling of COVID-19 is guided by Law no. 4/1984 on Infectious Diseases, Law No. 36/2009 on Health, Law no. 2/2007 on Disaster Management and Law No.6/2018 on Health Quarantine. The GoI recently passed several guiding regulations and technical guidance in response to the pandemic. Relevant analysis of the parent ESSA remain relevant. A summary of the review of pertinent policies, laws and regulations associated with COVID-19 vaccination is presented in this subsection. Further analysis of enforcement, capacity, as well as challenges, is further elaborated in Section D.

C.1.1 COVID-19 Vaccination Program

45. The objectives of the vaccination are three-pronged, including i) reducing morbidity and mortality associated with COVID-19, ii) achieving herd immunity and iii) maintaining productivity and minimizing social and economic impacts of the pandemic. Prioritization and staging of COVID-19 vaccination will weigh in these objectives, with identification of high-risk populations remaining under discussion. For the purpose of these objectives, the program will need to ensure high coverage of COVID-19 vaccination based on epidemiological characteristics and trends across the country.

46. A Presidential Regulation no. 99/2020¹⁶ on Procurement and Implementation of COVID-19 Vaccines appointed MOH as the main implementer of the national COVID-19 vaccination program. Following this regulation, a number of guiding regulations have been issued. These include ministerial regulation of MOH no. 28/2020 on the implementation of COVID-19 vaccine procurement and ministerial regulation of MOH no. 84/2020 on the implementation of COVID-19 vaccination that are subsequently replaced by MOH regulation no. 10/2021.

47. Eligible vaccines are those meeting safety, quality and efficacy requirements, subject to issuance of Emergency Use Authorization (EUA) by the National Agency of Drug and Food Control (BPOM). Procurement of vaccines may start in the absence of such EUA for the purpose of securing supply. However, vaccine administration is conditional upon issuance of EUA of specific vaccines concerned.

48. Presidential Regulation no. 99/2020 defines the roles of MOH the main agency to procure, set price and implement the national COVID-19 vaccination. Under this regulatory framework, MOH is responsible for establishing a) types of vaccines and needs, with recommendation from the Committee for Handling COVID-19 and National Economic Recovery (KPCPEN); b) criteria and prioritization of population groups; c) geographic prioritization; d) vaccination schedules, and e) service standards. The regulation also clarifies the roles of other government ministries, agencies and working groups/committees, and sub-national governments. These include KPCPEN, the National Agency for Food and Drug as the main partner for pharmacovigilance, and state-owned

¹⁶ Issued on October 6th, 2020

pharmaceutical companies¹⁷ as vaccine procurement agents. Although MOH will procure and distribute vaccines, provincial and district governments will manage the operations of public health facilities and services, where vaccines will be administered. Relevant roles and responsibilities of these stakeholders are further elaborated in **Table 3**.

49. Through the Presidential Regulation no. 14/2021, the Presidential Regulation No. 99/2020 is amended to include provisions on termination of COVID-19 contract in the event of force majeure; transfer of legal responsibilities from COVID-19 vaccines manufactures to the government in the case the manufacturers/providers require such taking over legal responsibilities, including on aspects related to safety, quality, and efficacy of immunogenicity; the mandatory nature of COVID-19 vaccination and administrative sanctions for people who is designated as a target recipient but does not participate in the vaccination. The other provisions under the Presidential Regulation No. 99/2020 that are not amended remain valid.
50. MOH regulation no. 28/2020 covers procurement of vaccines and their supporting instruments (e.g. syringes, PPEs, cold chain, etc.), as well as their distribution to delivery points. In implementing the vaccination program, MOH can establish partnerships with external stakeholders, including the private sector (i.e. logistics, storage, distribution, etc.). A technical working group has also been established to provide advisory services and oversight.
51. MOH regulation No. 10/2021 regarding the COVID-19 vaccination implementation issued on 25 February 2021, replacing the previously issued regulation no. 84/2021. This regulation aims to provide guidance for central government, provincial government, district/city government, community and other stakeholders on the implementation of COVID-19 vaccination in the country. It covers provisions on: a) COVID-19 vaccines planning assessment, b) vaccines target recipients, c) distribution of vaccines and other supporting equipment and logistics, d) COVID-19 vaccines delivery, e) cooperation on COVID-19 vaccination implementation, f) Adverse Events following Immunization (AEFI) monitoring, g) communication strategy, h) monitoring and reporting, i) budgeting, and j) supervision.
52. MOH Director General of Disease Prevention and Control further issued technical guidance on COVID-19 vaccination implementation through decree no. HK.02.02/4/1/2021. The guidance provide further details on the roll-out of COVID-19 vaccination in the country and cover aspects such as planning, target recipients, budgeting, distribution of vaccines and other supporting logistics, vaccination implementation, cooperation, monitoring and reporting, monitoring of AEFI, communication strategy and evaluation.
53. Further regulatory analysis concerning relevant themes considered under the ESSA addendum is presented in the following sub-sections.

C.1.2 Prioritization and Allocation

54. The president announced on 16th of December 2020 that every Indonesian citizen is entitled to free COVID-19 vaccines. To do so, the GoI is committed to securing a multi-year financing of 2.4 billion for COVID-19 vaccination over the span of 3.5 years.
55. Despite global efforts to develop safe and effective vaccines and ramp up production capacity, the initial vaccine supply will likely be limited in its initial years of roll-out. Allocation into specific target groups takes into account the following factors, including prioritization to meet vaccination objectives, limited supplies, administration capacities, the current degree of uncertainty related to age-independent vaccine efficacy and safety for certain population groups (i.e. the elderly and people with co-morbidities).

¹⁷ These include PT. Bio Farma and its subsidiaries, including PT. Kimia Farma Tbk and PT Indonesia Farma Tbk

56. Frontline health workers have received priority allocation, following issuance of EUA by BPOM. Phase 2 of the vaccination targeted essential public service officers as well as the elderly. Initial roll out has relied on SinoVac manufactured by SinoVac Biotech (hereafter SinoVac). Additional types of vaccines, including AstraZeneca, have also been reported to have been distributed, with more brands being expected to be more readily available in the near future. While there has been a shift from the initial focus on economic recovery to protection of the vulnerable groups to reduce mortality and morbidity, there is a lack of clarity on the correlations between evidence-based allocation to achieve the vaccination objective with the actual allocation, which appears to prioritize the former (i.e., economic recovery).

Table 2: GoI Planned Allocation of COVID-19 Vaccination

Population Group		Number of Target Beneficiaries (millions)	% of Total Population
First Wave	Vaccination Period January–May 2021		
Phase 1	Health personnel. Vaccination will be conducted for health personnel in 34 provinces. This includes health assistants, support/administrative personnel, and students who are currently in professional training who also work in health service facilities.	1.5	0.65
Phase 2 a	Public service workers. Frontline public service providers, including teachers and other educational institution staff; military and police forces; other uniformed officers; judicial officers; strategic public service officers; those working at ports of entry, transportation stations, banks, utilities including electric/power companies, and clean water companies; and other officers involved in directly providing services to the community.	17.3	6.44
Phase 2 b	Senior citizens: 60 years old and above	21.5	8.00
Second Wave	Vaccination Period June 2021–March 2022		
Phase 3	Vulnerable population based on geographical location, social, and economic aspects	63.9	23.66
Phase 4	Wider population; economic actors using a cluster approach according to the availability of vaccines	77.4	28.66

C.1.3 Targetting

57. For the initial phase of vaccination, identification of target and prioritized populations was developed top-down by the Central Government with technical considerations from the KPC-PEN, responsible to lead the overall planning and operational measures to respond to COVID-19 emergency. This relies on the existing population databases, including those administered by MOH (Information System on Health Human Resources/SISDMK), BPJS Health (PBI JKN recipients), BPJS Employment, Ministry of Home Affairs' population and civil registration database (Dukcapil SIAK), institutional databases from the Military and Police Forces. These multiple datasets have been consolidated into the One Data Information System for COVID-19 Vaccination (*Sistem Informasi Satu Data Vaksinasi COVID-19*). The Ministry of Communication and Information is responsible to inform target beneficiaries using an "SMS Blast" platform through identified phone

numbers, in partnership with telecommunication providers. However, there is no available guidance pertaining to reconciling data inconsistencies and discrepancies. In anticipation of exclusion and inclusion errors in the central registry, the draft technical guideline for COVID-19 vaccination has incorporated a bottom-up vaccine registration mechanism. However, such a mechanism requires NIK an eligibility criteria, which can potentially exclude individuals without NIKs.

C.1.4 Hazardous Waste Management

- 58.** The potential wastes generated from COVID-19 vaccination, including waste from vaccination activities (e.g. used syringes, vials, PPEs, etc.), are considered as hazardous wastes under the country's applicable hazardous waste regimes. Government Regulation No.101/2014 on Hazardous waste management casts the country's main hazardous waste management framework, while the MOEF Regulation No. 56/2015 on Hazardous Waste Management from healthcare facilities outlines the specific requirements on the management of hazardous medical wastes from all healthcare facilities, including from hospitals and *puskesmas*. These regulations specify relevant standards for medical waste management – including the requirements to reduce, reuse and recycle, as well as requirements of their packaging, storage, transportation, treatment and disposal, which are consistent with the GIIP¹⁸. The requirements under these regulations were built upon a “cradle to grave” principle with a rigid manifest system to track the flow of wastes from the generator to the disposal facility.¹⁹ The requirements prescribed under the government regulations are applied not only to the vaccination activities, but also to the distribution of the vaccines. The management of wastes that could possibly generated from the distribution activities, both conducted by private or public sector, are required to follow the guideline and standard as prescribed in the regulations.
- 59.** Managing hazardous wastes also forms part of the accreditations requirements for hospitals and *Puskemas*. MOH regulation No. 34/2017 on Hospitals accreditation outlines the requirements for hospitals accreditation, in which the performance standards are further defined in the National Standards for Hospital Accreditation (SNARS), whereas the MOH Regulation No. 46/2015 outlines the requirements for primary healthcare facilities accreditation. Both accreditations require hospitals and *Puskemas* to manage their hazardous waste through sets of criteria which are in accordance to the GIIP²⁰. Through the on-going Supporting Primary Health Care Reform PforR (I-SPHERE – P164277), the implementation of primary healthcare accreditation system is being enhanced, including to support the facilities in managing their hazardous wastes.
- 60.** In managing waste generated from COVID-19 response, MOH issued a guideline on the management of COVID-19 wastes in healthcare facilities through the issuance of Ministry of Health Decree No. HK.01.07/MENKES/537/2020 pertaining medical waste management from healthcare and quarantine facilities. Similar guidance has also been provided by Ministry of Environment and Forestry (MOEF) through the issuance of circular letter No. SE.2/MENLHK/PSLB3/PLB.3/3/2020 on infectious (hazardous) and domestic waste management from COVID-19 response. Both guidances provide discretionary measures which allows healthcare facilities to use their existing treatment facilities (e.g. incinerators or autoclaves) although the said equipment have not received licensed from MOEF and disposal of wastes in burial pits for facilities without onsite treatment

¹⁸ GIIP includes WBG General EHS Guideline: Waste Management, WBG EHS Guideline for Healthcare facilities and WHO safe management of wastes from health-care facilities

¹⁹ The newly issued Governmental Regulation No. 22/2021 on the Implementation of Environmental Protection and Management amended several articles in the Government Regulation No. 101/2021 on Hazardous Waste Management. The changes are mostly on permitting procedures for hazardous waste facilities and did not change the technical requirements in managing the hazardous waste.

²⁰ GIIP includes WBG General EHS Guideline: Waste Management, WBG EHS Guideline for Healthcare facilities and WHO safe management of wastes from health-care facilities

facilities or access to third-party waste handling—especially for the ones located in rural area. The guideline also provide technical standards that has to be met for these alternative measures.

61. Guidance on the management of wastes generated from general immunization activities is outlined in the MOH Regulation No. 12/2017 on Immunization implementation. The regulation provides detailed guidance on the treatment/processing of vaccination-related wastes such as used syringes, vials, and PPEs). A specific guideline on COVID-19 vaccination waste has also been included in the technical guideline on COVID-19 vaccination services that was issued by MOH.²¹ The technical guideline outlines the requirements on managing infectious and non-infectious waste that will be generated during COVID-19 vaccination including used syringes, vials, PPEs, etc. It provides alternatives in managing the waste such as through incineration/non-incineration method (autoclave/microwave), licensed third-party contracts, and burial. The technical guideline is primarily adopting the waste management approaches as prescribed in MOH Regulation No. 12/2017.
62. In ramping up the logistical support for waste management during the COVID-19 vaccination campaign, Presidential Regulation No. 99/2020 on Procurement and implementation of COVID-19 vaccines has also identified the needs to provide supporting equipment such as safety boxes to stored used syringes before further treatment or disposal.

C.1.5 Occupational Health and Safety

63. The country's OHS regulation regime consists of a comprehensive set of regulations to govern this aspect, such as Law No. 36/2009 on Health (section XII) and Government Regulation (PP) No. 50/2012 on Health and Safety Management, which required hospitals and other health care facilities to oversee and ensure the workers' safety and health by implementing an OHS management system. Specific guideline on how to implement the management system in a hospital setting are prescribed in MOH regulation No. 66/2016 on Hospital's occupational health and safety. These regulations applied to both private and public healthcare facilities. In addition to the country's overarching OHS law and government regulations, OHS requirements in healthcare settings are also outlined in the hospitals and *puskesmas* accreditation criteria. COVID-19 Infection Prevention and Control (IPC) guideline²² has been issued by MOH to provide advice for various stakeholders in managing the pandemic, including in healthcare settings. A specific health protocol for COVID-19 IPC in healthcare facilities, including private and public hospitals and *puskesmas*, has also been issued by MOH through Decree No HK.01.07/MENKES/1591/2020. The protocol includes the needs to provide regular health screening for healthcare workers (including supporting personnel), PPEs, and IPC training, as well as set the maximum working hours for healthcare workers.
64. COVID-19 vaccination can be administered in hospitals, clinics, *Puskesmas* and health posts at ports of entry. Only facilities meeting GOI's requirements for vaccination can administer COVID-19 vaccination, including a) availability of personnel, b) availability of cold chains suitable to specific requirements of vaccine types, c) valid operational license. MOH's technical guideline for COVID-19 vaccination also introduced several measures pertaining to OHS requirements during vaccine administration. These include a) priority vaccination for those administering vaccination, including supporting personnel; b) application of health and basic hygiene protocols, and use of PPEs, c) social distancing requirements, d) fatigue management by capping daily quotas.

²¹ Directorate General of Disease Prevention and Control Decree No. HK 02.02/4/1/2021, issued January 2, 2021.

²² 5th Revision, issued on 13th July 2020

65. Through the Presidential Regulation No. 99/2020, GoI has also identified PPEs as one of the supporting equipment that need to be procured and provided to healthcare facilities for the vaccination campaign.

C.1.6 Public Health and Safety, including Patient Consent

66. While patient rights are protected by law (i.e., the Indonesian's Constitution (Article 1) and Laws (Law on Health Articles 4 – 8, Law on Hospitals No. 44/2009, Article 2, Article 43), patients' consent requirements can be waived under emergency situations in the interest of public safety (Law on Health no. 36/2009, Article 56 – 58 and Law on Health Quarantine no. 6/2018).
67. The Presidential Regulation no. 14/2021 was promulgated to enforce COVID-19 vaccination in Indonesia. Relevant provisions include:
- a. Articles 13A and 13B: persons designated by MOH's data collection and listed as target recipients of the vaccine are required to participate in the vaccination, unless they do not meet the criteria for receiving the vaccine as per the indications for the available vaccine.
 - b. Anyone who is designated as a target recipient who does not participate in the vaccination, may be subject to administrative sanctions in the form of:
 - postponement/termination of social security/social assistance); suspension or termination of government administration services; and or fines.
 - In addition to the above, anyone who is a target recipient and does not participate in the vaccination and causes obstruction to the implementation and prevention of the spread of COVID-19 may be subject to – in addition to the administrative sanctions above – sanctions in accordance with the law on infectious disease outbreaks.
68. MoH Regulation No. 10 of 2021 on vaccination for the handling of COVID-19 pandemic serves as an implementing regulation of the above Presidential Regulations (14 of 2021). The MoH Regulation provides that the eligibility of COVID-19 recipient will be determined based on the available vaccine indications and based on the assessments of the Indonesian Technical Advisory Group on Immunization and/or Strategic Advisory Group of Experts on Immunization of the World Health Organization (SAGE WHO). This MoH Regulation further provides that in carrying out its data collection and determination of the COVID-19 Vaccine target recipients, the data on target recipient that would be collected in the Government's One Date COVID-19 Vaccination Information System⁽⁶⁶⁾ shall be prepared “based on the criteria of COVID-19 Vaccine recipient and the target's willingness to receive the COVID-19 Vaccine, which contains the name and address (by name and by address), as well as personal identification number [of the target].” The MoH Regulation clarifies how MoH is to cooperate with other institutions in implementing COVID-19 vaccination, including with subnational governments includes: (a) support through the provision of healthcare workers; (b) sites for vaccination; (c) logistic/transportation; (d) warehouse and vaccine storage; (e) safety; (f) socialization and community mobilization; (g) provision in non-healthcare worker and (h) medical waste management. Subnational governments, i.e., provincial governors and city/municipality regent/mayors are required, along with MoH, to coordinate the implementation of COVID-19 vaccination at every stage, including preparation, implementation and monitoring and evaluation implemented within their respective regions.
69. In line with the Presidential Regulation no.14/2021, the MOH Regulation no.10/2021 makes reference to administrative sanctions since a lower level regulation cannot contradict a corresponding higher-level regulation. However, the MoH regulation does not provide further details on the actual amounts and modalities for administrative sanctions. As currently there is no technical manual and/or operational guidance to implement such administrative sanctions, enforcement of these measures is considered highly unlikely in the absence of such documents.

Further, it contains a provision to provide for target populations' willingness to be registered to the GoI's vaccination program (Article 13).

- 70.** In summary, these regulations specific to COVID-19 vaccination: (i) require the Ministry of Health (MoH) to collect personal data to identify COVID-19 Vaccine target recipients, and in doing so, requires the collection of said personal data to be based on the target's willingness to receive the COVID-19 Vaccine; (ii) provides for an exemption from vaccination if the target recipient does not meet the criteria for receiving the vaccine as per the indications for the available vaccine; (iii) provides the possibility to impose administrative sanctions on target vaccine recipients who refuse to be vaccinated; and (iv) provides the possibility to impose criminal sanctions on target vaccine recipients who refuse to be vaccinated *and* cause an impediment to the handling of the spread of COVID-19, cross-referencing to a 1984 Infectious Disease Law.
- 71.** Apart from the above-referenced Regulations, there are no general laws on vaccination, though the 2009 Health Law provides the basic right of access to healthcare, and two laws, the 1984 Infectious Disease Law and the 2018 Health Quarantine Law, have been referenced as sources prescribing criminal sanctions for refusal to be vaccinated (the 1984 Infectious Disease Law in particular was referred in the specific Presidential decree no.14/2021 on COVID-19 Vaccination). At present, there seems to be only one known case during the last 37 years where any criminal sanctions (under both the 1984 Infectious Disease Law and the 2018 Health Quarantine Law) have been sought against an individual, and this was not in the context of the individual refusing to be vaccinated. There are also no known cases where the Government imposed administrative sanctions for those refusing to be vaccinated. A provincial regulation from DKI Jakarta province (No. 2 of 2020) is the only known regulation at the subnational level that provides for a IDR 5 million (or about US\$ 330) fine for every person "who deliberately refuse[s] to receive treatment [for COVID-19] and/or COVID-19 Vaccination."
- 72.** Given the history and on the basis of the current legal framework, whether any sanctions are enforceable is still a matter of debate and it is unclear whether such sanctions will be enforced. The COVID-19 vaccination manual as stipulated in the Minister of Health's decree no. 01.07/Menkes/4638/2021 does not provide any instructions on the application of administrative sanctions and other punitive measures under the GOI's vaccination program. As of to date, the ESSA addendum could not confirm other relevant legal measures to enforce the sanctions as envisaged in the Presidential Regulation. Further, media reports suggest that there is also a commitment by the government to the House of Representatives (DPR) Committee IX that vaccination will not be forced.
- 73.** Based on the above assessment, the risk of use of force for those not accepting vaccination is perceived to be very low. This residual risk is mitigated through covenants in the legal agreements as well as the Program action plan. As per the provisions applicable to the World Bank's Multiphase Programmatic Approach under which this Program is financed, use of force represents a key limitation to what the World Bank can finance. Mitigating actions in the Program Action Plan that support the avoidance of force include the provisions for strong public communications to support a primarily persuasive approach, the provisions for a Feedback and Grievance Response Mechanisms (FGRM), and provisions to inform health workers and patients around the medical code of ethics and for respectful behavior towards patients.
- 74.** In the event of Adverse Events following Immunization or AEFI (*Kejadian Ikutan Paska Imunisasi* or hereafter KIPI), ministerial regulation of MOH no. 12/2017 on Immunization provides an overarching framework for the handling of KIPI. The regulation requires the establishment of independent committees at the national and sub-national levels by the minister of MOH and governors respectively to undertake KIPI surveillance and investigation. These committees are staffed by medical specialists, including paediatricians, internists, obygns, neurologists, forensics, pharmacologists, immunologists, vaccinologists and other personnel from relevant sectors. MOH's COVID-19 vaccination guideline includes relevant procedures for KIPI surveillance and reporting.

Patients are eligible for medication and treatments during the investigation and causality analysis of KIPI and additional treatments if reported cases are vaccination-related. The regulation does not further elaborate whether patients are eligible for additional compensation.

75. Under the Presidential Regulation no.14/2021, the government takes over legal responsibilities for providing COVID-19 vaccines, including on aspects related to safety, quality, and efficacy of immunogenicity if the manufacturers/providers require such taking over of legal responsibilities. Taking over of legal responsibility is granted up to the revocation of the health emergency, and if there are cases of adverse events following vaccination where the vaccination was carried out or vaccines were procured before the revocation of the health emergency, the government still takes over legal responsibilities. Financial compensations will be provided to cases leading to fatalities and/or permanent disabilities, with further details, including amounts to be regulated by the Ministry of Finance. In parallel, there is also a provision for free treatment of any complications arising out of COVID-19 vaccination, which is included in the MOH guidance.
76. In the event of KIPI, healthcare workers cannot be sued by any legal means in the context of emergency for life-saving treatments (Law on Health no.36/2009, Article 58, point 2). This may result in lack of ability for patients and families to charge medical professionals for malpractices leading to injury, disabilities or even deaths under the criminal code (*Kitab Undang-Undang Hukum Pidana*). Medical negligence and litigation implicating medical professionals (doctors and dentists) are investigated by the Indonesian Medical Disciplinary Board (*Majelis Kehormatan Disiplin Kedokteran Indonesia*/MKDKI). The MKDKI is an autonomous body of the Indonesian Medical Council (KKI) and is authorized to issue testimony/statements with regards to negligence or mistakes or ethical issues in medical practices as well as remedial measures necessary including sanctions. Under these circumstances, the use of civil code (*Kitab Undang-Undang Hukum Perdata*) may be pursued, and complaints may be settled through financial compensation for improper services.

C.1.7 Feedback and Grievance Mechanism

77. Public service accountability includes citizens' rights to provide feedback and file grievances. Such rights are protected by law. Law no. 25/2009 on Public Service governs the interactions, expectations, rights, responsibilities, and discretions between all parties involved in public service delivery, including end users and service providers. In 2008, the GoI issued Law no. 4/2008 on Access to Public Information which affirms citizens' access to information from government organizations, including State-Owned Enterprises (SOEs). The Law also specifies types of disclosable information and procedures to obtain such information.
78. Most vaccinations will likely be administered at primary healthcare centers (or hereafter *Puskesmas*). By law, *Puskesmas* needs to establish service agreements with the communities in their respective jurisdictions on the basis of which they operate (Ministerial Regulation of MOH no. 46/2015). Such service agreements will define minimum service standards, including operating hours, codes of conduct, complaint-handling mechanisms, etc. MoH's commitments to enhance public health accountability is reflected in their Health Strategic Plan (*Rencana Strategis* or hereafter *Renstra*) where *Puskesmas*' performance targets include responsiveness to public feedback and complaints. The on-going PforR on Supporting Primary Health Care Reform (I-SPHERE – P164277) supports MoH in strengthening MoH's primary healthcare accreditation system, where two of the agreed enhancement measures include disclosure of grievance records by *Puskesmas* to enhance transparency and accreditation system strengthening in assessing FGRM performance at the facility level.
79. Due to various uncertainties related to public health risks associated with COVID-19 vaccination, enhancement in public health service accountability, particularly through bottom-up processes to promote citizens' participation in the overall delivery of COVID-19 vaccination will be critical. Such efforts are expected to strengthen pharmacovigilance measures that the AF is supporting.

C.1.8 Data and privacy

80. Protection of civil rights to privacy and private data is fragmented across regulations and no overarching law in existence for the purpose, with weak protection of individual rights to personal data²³. Indonesia has 32 laws and regulations which govern the protection of personal data/ privacy. No single comprehensive law is in place for the protection of private data, which in some circumstances results in abuse of private data collected through Banking transactions and social media for commercial purposes, with risks of fraudulent appropriation of personal data for criminal conducts. The Bill on Private Data Protection, which consolidates citizens' rights to data protection and privacy, is pending approval from Parliament. This represents a gap in the regulatory framework.
81. For the purpose of COVID-19 surveillance, MOH's Centre of Data and Information (Pusdatin) is leading the development of an electronic platform integrating Tracking COVID-19 application with Allrecords TC 19, with the former serving as a dashboard to MOH management and the latter serving as a data entry platform. A protocol for data protection measures has been drafted, including a measure to encrypt individual data points. The tracking application, including data storage and protection, is oversighted by the State Cyber and Code Agency (BSSN). Implementation of such data protection measures remain to be observed.
82. Under the AF, a guideline for personal data protection for the purpose of COVID-19 vaccination has been developed by the MOH's Pusdatin. Pusdatin has adopted [ISO 27001 on Information Security Management](#) where relevant measures such as Smart Checking to allow access to only authorized officers and Non-disclosure Agreement (NDA) have been in place. Since COVID-19 vaccine data entry points will mostly be located at the sub-national level, the existing guideline on data protection will need to be further operationalized to include relevant measures in the event of breach, violation to the integrity pacts, and data leakages at data entry points.

C.2 Institutional Responsibilities

83. MOH is the proposed implementing agency for the AF with the overall coordination responsibility in the Secretary General's Bureau of Planning and Budgeting. The Program will be implemented by multiple directorat generals within MOH, responsible for achievement of agreed Disbursement Linked Indicators (DLIs). These include the Director Generals of Health Services, Disease Control, the Health Human Resource Board, and the Institute of Research and Development.
84. In defining relevant recommendations for environmental and social enhancement measures under the AF, relevant stakeholders were identified as part of the ESSA addendum. Within the Program boundaries, such recommendations are focused on MOH as the implementing agency for the AF. For the purpose of the assessment, key stakeholders are categorized as follows (refer Table 3):
 - a. Category 1: Implementing stakeholders within MOH. Program Action Plans (PAPs) will be recommended to these stakeholders.
 - b. Category 2: External stakeholders contributing to the management of the environmental and social aspects of the PforR. Collaboration and engagement will be sought as part of the AF preparation and implementation.

²³ Six of those are related to health sector include Law No 29/2004 on Medical Practice, Law No 36/2009 on Health, Law No 44/2009 on Hospital, Law No 18/2014 on Mental Health, and Law No 35/2009 on Narcotics. Article 57 (2) of Law, No 36/2009 on health, stated that exception on data protection could be made in several conditions include for public health interest by respecting the necessity and proportionality principles. Furthermore, Minister of Health Regulation No. 269/MenKes/Per/III/2008 on Medical Records stated that all health facilities must maintain the confidentiality of the patient's medical records except for extraordinary circumstances for health and safety reasons, law enforcement, at the request of the patient(s) concerned, and for research and education purpose without disclosing the patient's identity.

- c. Category 3: Broader stakeholders involved in the implementation of COVID-19 vaccination (GoI's Program), where the PforR is part of. Engagement and information sharing will be sought with these stakeholders during PforR implementation.
- 85.** The proposed AF institutional arrangement takes cognizance of Indonesia's decentralized government system and hence, the focus will be placed on facilities where MOH has direct influence and control.
- 86.** While broader risks were assessed under the ESSA addendum, PforR action plans (PAPs) for the environment and social management were intended for relevant departments within MOH responsible for Program implementation (i.e., stakeholders under Category 1).
- 87.** **The following table provides a summary of the institutional responsibilities with respect to the GoI's COVID-19 vaccination and how they are related to the proposed AF.**

Table 3: Institutional Responsibilities for Environmental and Social Performance

Institutions	Institutional Responsibilities in the GoI led COVID-19 Emergency Response	Institutional Responsibilities in PforR
Category 1: Implementing Stakeholders within the Program		
Ministry of Finance	<ul style="list-style-type: none"> - Setting policies on budget allocation and re-allocation for COVID-19 emergency response - Overall monitoring of COVID-19 emergency response spending 	<ul style="list-style-type: none"> - Signatory of the loan agreement - Provision of financing to achieve agreed DLIs
Secretary General of MOH	<ul style="list-style-type: none"> - Provide strategic direction and guidance for COVID-19 vaccine coordination; - Provide technical inputs to the national emergency response (COVID-19 handling) as a member of the task force COVID-19 handling and National Economic Recovery Program. 	<ul style="list-style-type: none"> - Chair the Program Steering Committee, including liaising communication and coordination at the Echelon 1 level (Directorate Generals/DGs); - Lead coordination with relevant departments within MoH and external ministries/agencies.
Bureau of Planning of MOH	<ul style="list-style-type: none"> - Coordinate planning of COVID-19 vaccination including developing cost estimates for the vaccine procurement, and its related operational and logistic requirements; - Develop a budget workplan covering allocation of financial resources across relevant directorates within MoH; - Liaise with the Ministry of Finance (MoF) on budget allocation. 	<ul style="list-style-type: none"> - Lead the program coordinating unit in the implementation of the PforR; - Ensure availability of information required to monitor PforR implementation; - Undertake requisite supervision and reporting during PforR implementation.
Center of Health Data and Information (Pusdatin) of MOH	<ul style="list-style-type: none"> - Integrate information systems related to pandemic response; - Lead the development of a COVID-19 situation data platform; - Develop manuals for information collection, including quality assurance, data protection and confidentiality. 	<ul style="list-style-type: none"> - Provide overall monitoring of COVID-19 pandemic and government response, including COVID-19 vaccine roll-out; - Develop a dashboard for internal MOH/Government, including for the broader public.
Center for Health Crisis of MOH	<ul style="list-style-type: none"> - Revise the Health Sector Pandemic Operation Plan based on inputs and comments from the Intra-Action Review (IAR); - Develop a Personal Protective Equipment (PPE) plan for COVID-19 vaccination, including need estimates and a deployment plan 	<ul style="list-style-type: none"> - Monitor the implementation and deployment of PPE for the purpose of COVID-19 vaccination.
Directorate General of Pharmaceutical	<ul style="list-style-type: none"> - Ensure availability of pharmaceuticals and health equipment for COVID-19 response, such as cold chains logistical support (i.e. 	<ul style="list-style-type: none"> - Lead procurement of COVID-19 vaccines and logistical support in collaboration with other relevant government entities;

Services for Medical Supplies of MOH	<ul style="list-style-type: none"> - automatic voltage stabilizers (AVS), standby generators, safety boxes, etc.); - 	<ul style="list-style-type: none"> - Liaise with the National Agency of Drug and Food Control (BPOM) for pharmacovigilance and <i>Halal</i> certification.
Bureau of Communication and Public Services of MOH	<ul style="list-style-type: none"> - Public health communication on healthy behaviour, preventive measures, vaccine related issues, etc.; - Handling of grievances (submitted through Halo Kemkes). 	<ul style="list-style-type: none"> - Public risk communication on COVID-19 vaccine related issues (i.e. effectiveness, post-vaccination adverse events, etc.); - Monitor public acceptance of COVID-19 vaccination (pre- and post- roll out); - Provide counter-measures to address misinformation and hoaxes related to COVID-19 response, including COVID-19 vaccination.
Directorate of Referral Services of MOH	<ul style="list-style-type: none"> - Provide quality assurance, technical guidance and supervision of health care facilities (i.e. hospitals). 	<ul style="list-style-type: none"> - Oversee implementation of COVID-19 vaccination at health care facilities (i.e. hospitals).
Directorate of Primary Health Services of MOH	<ul style="list-style-type: none"> - Provide quality assurance, technical guidance and supervision of primary health care facilities (<i>Puskesmas</i>). 	<ul style="list-style-type: none"> - Integrate implementation of a COVID-19 vaccine program to the existing national immunization program and administer COVID-19 vaccination at the primary healthcare facilities; - Lead a Cold Chain Equipment Management (CCEM), including inventory of cold chain equipment; - Provide regular reporting and recording of immunization services.
Directorate of Surveillance and Health Quarantine of MOH	<ul style="list-style-type: none"> - Lead identification, targeting and tracing of COVID-19 cases; - Conduct a country readiness assessment for COVID-19 vaccination roll-out (under the available instruments); - Develop a country-level COVID-19 vaccine roadmap/implementation plan; - Lead coordination with technical departments and related stakeholders for COVID-19 vaccine provision and implementation; - Ensure availability and reliability of COVID-19 surveillance information. 	<ul style="list-style-type: none"> - Lead surveillance activities, including scale up; - Lead the development of a vaccine implementation roadmap; - Lead technical dialogues with technical departments and development partners/counterparts; - Participate in the development and strengthening of the national pandemic preparedness plan.

Sub-directorate of Immunization of MOH	<ul style="list-style-type: none"> - Implement national vaccine programs including the COVID-19 vaccination campaign. Its responsibilities include: a) produce and disseminate technical guidance, b) estimate the needs and costs for COVID-19 vaccines and related supplies, assesses and plans for Cold Chain Equipment (CCE including ultra cold chain if needed), and c) estimate the size of human resources and its training; ensure quality assurance; and provides supervision and monitoring and evaluation. 	<ul style="list-style-type: none"> - Implement the national COVID-19 vaccination program
Directorate of Health Promotion of MOH	<ul style="list-style-type: none"> - Lead public health communication and campaign on healthy behaviors and be in charge of the development of behavioural change communication manuals. 	<ul style="list-style-type: none"> - Lead public health campaign on healthy behaviour and COVID-19 vaccination (i.e. efficacy, side effects, etc.)
Directorate of Environmental Health of MOH	<ul style="list-style-type: none"> - Provide technical guidance/procedure in managing wastes from COVID-19 vaccination activities in healthcare facilities - Ensure the implementation of waste management measures to protect frontline health workers that include professional health workers, administrative and other supporting staff at health facilities (mortuary personnel, laundry, cleaning service) 	<ul style="list-style-type: none"> - Liaise with MOEF and Directorates of Referral and Primary Health Services in the provisions of advice and guidance on the implementation of hazardous waste management of COVID-19 vaccine wastes across hospitals and healthcare facilities.
Secretary of the Board for Planning and Empowerment of Human Resource for Health (Badan PPSDM) of MOH	<ul style="list-style-type: none"> - Manage the database of frontline Human Resource for Health (HRH) including medical and non-medical support staff responsible for COVID-19 response; - Implement an incentive scheme and death compensation payments for health workers. 	<ul style="list-style-type: none"> - Maintain frontline HRH databases as the priority groups for COVID-19 vaccination; - Monitor vaccine acceptance and pharmacovigilance for frontline HRH.
The National Institute for Health Research and Development (NIHRD), especially the Center for Biomedics and Health Technology	<ul style="list-style-type: none"> - Provide technical guidance/standards for medical and public health laboratories, both public and private, and ensure the quality in providing COVID-19 related services, including but not limited to confirmatory testing, and genome sequencing, - Implement the external quality assurance framework to all laboratories in the network - Monitor the involvement of the Ministry of Health in the global efforts to track COVID-19 variants 	<ul style="list-style-type: none"> - Maintain database on the reporting of confirmatory testing for COVID-19 - Monitor the implementation of the external quality assurance (EQA) - Monitor the implementation of the genome sequencing
Category 2: External Stakeholders Contributing to Environmental and Social Management for the AF		
Committee for Handling COVID-19 and National	<ul style="list-style-type: none"> - Lead the overall planning and operational measures to respond to COVID-19 emergency 	<ul style="list-style-type: none"> - Issue regulations for COVID-19 vaccine implementation

Economic Recovery (KPCPEN)		<ul style="list-style-type: none"> - Serve as a policy maker for COVID-19 vaccine distribution schemes; - Integrate population data for vaccination targeting across existing sources from line ministries/agencies, including MoH, BPJS, MoCI, and public authorities whose personnel are designated as priority recipients (i.e. the Military, Police Force, law enforcement agencies, Ministry of Education, etc.)
The National Agency of Drug and Food Control (BPOM)	<ul style="list-style-type: none"> - Supervise pre- and post-distribution of COVID-19 drugs 	<ul style="list-style-type: none"> - Issue an Emergency Use Authorization (EUA) which serves as a vaccine distribution permit; - Supervise pre- and post-distribution of COVID-19 vaccines; - Provide Halal certification assurance of COVID-19 vaccines; - Undertake pharmacovigilance services (i.e. collection, detection, assessment, monitoring, and prevention of adverse effects with COVID-19 vaccines)
The National Disaster Management Authority (BNPB)	<ul style="list-style-type: none"> - Lead the overall national planning and operational measures to respond to COVID-19 emergency 	<ul style="list-style-type: none"> - Chair the national COVID-19 Taskforce - Provide strategic direction,
Ministry of Home Affairs (MoHA)	<ul style="list-style-type: none"> - Sub-national government coordination, including with village governments - Population Administration Information System (<i>Sistem Informasi Administrasi Kependudukan</i> or hereafter SIAK) 	<ul style="list-style-type: none"> - Sub-national government coordination - Provision of population databases
Presidential Staff Office (<i>Kantor Staff Presiden</i>)	<ul style="list-style-type: none"> - Monitor and manage grievance and complaints redress related to Covid19 vaccination via LAPOR platform 	<ul style="list-style-type: none"> - Coordinate public communication on COVID-19 vaccination; - Designate focal point(s) for the implementation of COVID-19 vaccination;
Ombudsman	<ul style="list-style-type: none"> - Receive and investigate grievance related to the administration of Covid19 vaccination 	<ul style="list-style-type: none"> - Grievance management
Ministry of Environment and Forestry	<ul style="list-style-type: none"> - Provide technical and regulatory guidance on the management of COVID-19 related waste to healthcare facilities, transporters, and processing facilities 	<ul style="list-style-type: none"> - Provide guidance and advice on COVID-19 vaccination related waste management

	<ul style="list-style-type: none"> - Liase with MOH in providing advice and guidance on the implementation of hazardous waste management during COVID-19 to healthcare facilities 	
Ministry of Communication and Information (MoCI)	<ul style="list-style-type: none"> - Develop population wide communication of the program - Develop an individual reminder system (SMS Blast) - Develop a registration system as a part of the One Data for the Vaccination Program 	<ul style="list-style-type: none"> - Handle information dissemination under the One Data for COVID Vaccination, including public outreach - Monitor and countermeasures misinformation regarding COVID-19 vaccines
National Government's Finance and Development Monitoring Agency (BPKP)	<ul style="list-style-type: none"> - Serve as the government auditing agency 	<ul style="list-style-type: none"> - Serve as a verification agency for the PforR, including the AF
Category 3: Broader Stakeholders Involved in COVID-19 Vaccination Program		
Indonesian Technical Advisory Group on Immunization (ITAGI)	<ul style="list-style-type: none"> - Provide technical advice on government immunization program including COVID-19 vaccination 	<ul style="list-style-type: none"> - Provide inputs to the GOI on the prioritization and choice of vaccines

D INSTITUTIONAL CAPACITY AND PERFORMANCE ASSESSMENT

88. This section summarises key findings or gaps on the assessment of system implementation, including the capacity of the relevant institutions to effectively implement the environmental and social management systems in the parent PforR and additional systems described in the AF. Institutional capacity and performance were reviewed in reference to the on-going parent PforR implementation as well as the government immunization program, and how these will be calibrated to tackle the pandemic.

D.1 Implementation of Environmental and Social Action Plans of the Parent PforR

89. The progress towards achievement of the PDO and overall implementation progress were rated *Satisfactory* in the last Implementation Status and Results report as of August 23, 2020, and good progress was recorded during the mid-term review (MTR) conducted in October 2020. Amidst a pandemic that continues to progress, the GOI has scaled up its infrastructure and interventions to respond to COVID-19. For example, testing capacity for COVID-19 using Polymerase Chain Reactions (PCR) tests, considered the gold standard method for diagnostic testing, went up from around 3,000 tests per day in April 2020, to more than 70,000 tests per day by the end of October 2020 (MTR report 2020). Notable progress on implementation of agreed environmental and social action plans under the Parent PforR, with several areas for improvements. A summary of relevant achievement is presented in this section, with further details being appended in **Annex 3**.

90. On infection control and medical waste management: technical guidelines and/or strategy for infection control in relation occupational health and safety (OHS) and medical waste management at various health facilities along with relevant virtual training/coaching to health facilities and health workers have been conducted. The MOH has issued an appointment letter (*Surat Keputusan*) for the designated MOH's team to provide oversight on the management of medical wastes at healthcare facilities. A rapid assessment on medical waste practices and capacity has also been conducted. The mission team suggests the rapid assessment to cover wider respondents as COVID-19 healthcare facilities network has been expanding, and to provide disaggregated information by types of facility. MOH has also ramped up the waste management capacity in several provinces by distributing additional four autoclaves and four incinerators. The provision and deployment of Personal Protective Equipment (PPE), as a part of the infection control has followed the World Health Organization (WHO) recommended demand forecast tool, the Essential Supplies Forecasting Tool (ESFT), combined with a logistical distribution monitoring platform that are managed by the Center for Health Crisis. In order to protect health workers, the guideline on priority testing, not only to health workers but also health facility staff has been issued.

91. On public risk communication, patient safety and personal data protection: the integration of data protection measures in the surveillance protocol is currently on-going under the All Record Track COVID-19 platform and being implemented under the oversight from the State Cyber and Code Agency (*Badan Siber dan Sandi Negara - BSSN*). A public health campaign and communication strategy have been developed by MOH to support public awareness related to COVID-19 but it still requires tailored delivery measures to reach vulnerable groups, including people with disabilities and with low literacy. Such a strategy will also need to incorporate social stigma countermeasures through public awareness and education. An existing Feedback Grievance Redress Mechanism (FGRM) has been in operation and is processing feedback and complaints, although its level of effectiveness needs to be further assessed through a systematic analysis of available grievance records. Also functioning is the mechanism for patients' safety and security, which follows the national patient safety framework from the National Commission for Patient Safety (*Komite Nasional untuk Keselamatan Pasien – KNKP*). The MOH needs to enhance these existing systems through availability of relevant information about grievance channels and their management,

particularly to anticipate a surge of demands as a result of COVID-19 vaccination roll out. Areas to be considered include inter-sectoral and governmental coordination for grievance settlement, design and strategy public risk communication, as well as accessibility and visibility of these systems.

D.2 COVID-19 Vaccination Program

92. Indonesia’s massive, free COVID-19 vaccination program covering all of the 181.5 million adults in the country represents a major undertaking of an unprecedented scale. Achieving what is called “herd” immunity will require vaccinating a large proportion of population all at once. Vaccinating adults is much more complex than infants, especially when it may involve multiple doses which will add complexities of targeting and monitoring. The latest Indonesian Basic Health Survey reported that the proportion of fully immunized children was 58 percent, and 63 percent of all unvaccinated children were living in rural areas. As much as a three-fold difference in immunization coverage rates exist across provinces, and sizeable inequalities by economic status exist as well. An intense focus on expanding immunization capacity will therefore be required, and Indonesia must ensure that its health system can effectively implement a comprehensive, inclusive (and sustainable) COVID-19 vaccine deployment strategy.
93. COVID-19 vaccination being supported by the AF will be implemented by the same PIU for the parent PforR, which will remain coordinated by MOH’s Bureau of Planning. MOH has prepared a roadmap on COVID-19 vaccine implementation that includes a) prioritization on geographical coverage and population groups, implementation phases and timeline; b) implementation arrangement; c) system capacity assessment, including cold chains for vaccine distribution. A technical guideline on COVID-19 vaccination services has also been developed through a decree of Directorate General of Disease Prevention and Control No. HK 02.02/4/1/2021 to provide direction and practical guidance on the preparation, implementation, surveillance, as well as monitoring and evaluation of the program. At this stage of preparation, MOH is commissioning an assessment of vaccination readiness across delivery points in the country through a self-assessment undertaken by each District and/or Municipal Health Offices. BPJS-operated Primary Care Application (or hereafter [P-Care](#)) will be used as a platform to record and consolidate assessment findings on the basis of which planning decisions will be made. The same application will also be used to track implementation of COVID-19 vaccination at each delivery point.
94. Given the coverage of COVID-19 vaccination and anticipated demand, the GoI has adopted measures to secure vaccines from several sources (Table 44(continued)). Indonesia has signed an agreement on COVID-19 vaccine procurement under the GAVI COVAX facility, which assures free vaccines for 20 percent of the country’s population. Furthermore, the GoI has undertaken bilateral negotiations with potential suppliers from China, United States (US), and United Kingdom. Indonesia’s vaccine strategy will need to rely on vaccines that do not require ultra-cold supply chains. These include whole vaccine, viral vector vaccine and sub-unit vaccines, rather than mRNA-based vaccines.

Table 4: GoI’s Vaccine Procurement Plan (source: MOH - Updated)

National plan target (population, %)	COVAX grant	Other sources	Specific vaccines and sourcing plans
Stage 1 (0.65)	0	1,500,000	Sinovac, bilateral
Stage 2a (6.44)	6,000,000	3,440,000	Free COVAX, Sinovac, bilateral
Stage 2b (8.0)		5,000,000	Free COVAX, Sinovac, bilateral

Stage 3 (23.66)	20,000,000	43,900,000	Free COVAX, Astra Zeneca, paid COVAX, Sinovac, Novavax
Stage 4 (28.66)	28,000,000	49,400,000	Free COVAX, Astra Zeneca, paid COVAX, Sinovac, Novavax

95. As of the date the ESSA addendum the GoI has rolled-out its vaccination program in the second phase, having completed the first phase targeting 1.5 million frontline healthworkers across all provinces, with exemptions and exclusions for those with specified medical conditions, recent COVID-19 infection and pregnant women among them, and having achieved a 93 percent full vaccination rate in this group. EUA for SinoVac was released by BPOM on 11th of January 2021. On the same date, Indonesia Ulema Council (*Majelis Ulama Indonesia* or hereafter MUI) issued a halal certification for SinoVac. The second phase of vaccination has also been rolled out and is currently ongoing with Sinovac and COVAX vaccines (Astra Zeneca, which has also received BPOM authorization), targeting public service workers and the elderly, approximately 17.3 and 21.5 million respectively.
96. Although procurement and distribution of vaccines will be centralized, vaccination will be administered by provincial and district governments across their respective public health facilities and services. Further, a smaller parallel program for employers intending to self-finance and provide free vaccination for their employees, though not part of this Program, will also be available in due course. Management capacity and commitments to immunization greatly vary across different provinces and/or districts, leading to varying immunization coverage rates. While almost two-thirds (67 percent) of *Puskesmas* offer daily or weekly immunization services and 92 percent provide outreach services on a monthly basis, budget constraints for last-mile distribution services represent a barrier. Almost three-fourths of all vaccinated children in Indonesia receive their immunization at a sub-village level health post (*Posyandus*), followed by 10 percent at *Puskesmas*, 10 percent at private clinics and hospitals (although this can be as high as 50 percent in some provinces), and the remainder at a delivery village post (*Polindes*) and other places (including midwives' homes). These patterns reflect sheer challenges of vaccine delivery, which may affect availability and accessibility of COVID-19 vaccines in rural and lagging regions. mRNA-based vaccines, requiring ultra-cold chains, may not be readily be available in these regions.
97. As COVID-19 vaccination is being rolled out, adaptive management to accommodate different scenarios based on the latest scientific evidence about the efficacy, safety and logistical requirements of potential vaccines as well as the latest epidemiological data on the characteristics of COVID-19 infection and/or transmission across Indonesia will be critical. Further, since the majority of available and candidate vaccines will likely require double doses, the government also needs to develop a mechanism for follow-up and compliance monitoring to prevent attrition. There is a likelihood that there will be more than one type of vaccine being administered. Therefore, while a detailed arrangement of who administers, where and to whom each type of vaccine is dispensed has been recently developed in the COVID-19 vaccination guideline, the overall administration capacities remain to be observed, and will likely be stretched due to the scale and speed, and complexity of COVID-19 vaccination.
98. A national COVID-19 vaccination will require close cooperation with line ministries/agencies, sub-national governments, private entities, civil society organizations and communities at large. Further, an inclusive public communication strategy combined with a robust mechanism for oversight, including pharmacovigilance supported by a clear accountability framework to monitor adverse events and accessible and credible Feedback and Grievance Redress Mechanisms (FGRMs) will serve as critical platforms to support public health risk oversight and promote vaccine uptake going forward.

D.3 Environmental and Social Considerations

99. Further analysis of relevant capacities and environmental and social considerations corresponding to the areas of concerns is provided in the following sub-sections. The assessment was undertaken based on GoI’s existing capacity in the overall immunization Program and recent gains through COVID-19 emergency response.

D.3.1 Allocation and Prioritization

100. Vaccines are being planned and ordered for free vaccination of all adults in Indonesia, making it one of the frontrunner middle income countries of its size in doing so. Vaccine prioritization in Indonesia is generally aligned with the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and Indonesian Technical Advisory Group on Immunization (ITAGI – refer **Table 5**). As indicated in the technical guideline for COVID-19 vaccination, vaccination seeks to focus on reduction of direct morbidity and mortality and maintenance of most critical services, while considering reciprocity towards groups that have been placed at disproportionate risks to mitigate consequences of this pandemic (i.e. frontline health workers and public service officials). The government is taking a cautious approach of balancing the needs to inoculate the elderly and people with comorbidities to reduce deaths with the known safety and efficacy of procured vaccines. Although the initial plan was to prioritize adults of 18-59 years old to reach herd immunity among the more active members of the population more quickly, it was recognized that there was unclear evidence that vaccines can reduce transmission, and that this plan might not result in herd immunity. There are about 181.5 million people to be vaccinated (or 67 percent of the population), requiring 426 million doses of vaccines with a double-dose regimen and 15 percent wastage rate (Reuters January 4th, 2021). Indonesia has secured 125.5 million doses of China’s SinoVac vaccines, 108 million doses from the free COVAX supply and 50 million doses each of Astra Zeneca and Novavax vaccines, with another 50-100 million doses being requested from the paid COVAX option.

Table 5: Vaccine Prioritization

Stage	WHO SAGE recommendation for Community Transmission	GOI Prioritization
Stage I (very limited vaccine availability for 1-10 percent of national population)	<ul style="list-style-type: none"> - 1a. Health workers at high to very high risk of acquiring and transmitting infection - 1.b. Older adults defined by age-based risk specific to country/region 	High risk health workers at very high risk of acquiring and transmitting infection. These include frontline healthworkers and supporting staff, medical students interning at health facilities (Actual. timeline January – February 2021)
Stage II (limited vaccine availability for 11-20 percent of national population)	<ul style="list-style-type: none"> - Older adults not covered in Stage 1 - Group with comorbidities determined to be at significantly higher risk of severe disease or death. Efforts should be made to ensure equity to disadvantaged groups 	<ul style="list-style-type: none"> - Public service workers, including the military, law enforcement and public service personnel, including those providing transportation, banking, electricity, water services and other personnel directly involved in providing public services; - The elderly (60 years old and above), subject to the availability of safe vaccine for the age group.

	<ul style="list-style-type: none"> - Socio-demographic groups at significantly higher risk of severe disease or death²⁴ - Health workers engaged in immunization delivery (routine program and COVID-19) - High priority teachers and school staff 	(Ongoing; estimated timeline February – June 2021)
Stage III (moderate vaccine availability for 21-50 percent of national population)	<ul style="list-style-type: none"> - Remaining teachers and school staff - Other essential workers outside health and education sectors (i.e. police officers, municipal services, child-care providers, agriculture and food workers, transportation workers, government workers essential to critical functioning of the state not covered by other categories) - Pregnant women - Health workers at low to moderate risk of acquiring and transmitting infection - Personnel needed for vaccine production and other high-risk laboratory staff - Social/employment groups at elevated risk of acquiring and transmitting infection because of inability and/or lack of ability to exercise physical distancing 	Vulnerable groups due to geospatial, socio-economic factors (Est. timeline June 2021 – March 2022)
Stage 4	N/A	The broader public and other economic actors not included above (based on vaccine availability) (Est. timeline October 2021 – March 2022)

D.3.2 Population Targeting and Exclusion

101. As scientific evidence for COVID-19 vaccines is evolving rapidly and new COVID-19 variants are being identified, there exists significant uncertainty and unknowns regarding the efficacy, effectiveness, and safety of existing and potential vaccines, especially against the emerging variants. In the light of evolving evidence, it is important for the government to prepare for different scenarios of prioritization based on the most current scientific results of the vaccines' safety, efficacy, and effectiveness as well as their availability. This includes preparing databases and rosters of eligible

²⁴ This will depend on country context, examples may include: disadvantaged or persecuted ethnic, racial, gender, and religious groups and sexual minorities; people living with disabilities; people living in extreme poverty, homeless and those living in informal settlements or urban slums; low-income migrant workers; refugees, internally displaced persons, asylum seekers, populations in conflict settings or those affected by humanitarian emergencies, vulnerable migrants in irregular situations; nomadic populations; and hard-to-reach population groups such as those in rural and remote areas (WHO SAGE)

and prioritized individuals under different scenarios. For example, if a candidate vaccine is declared safe and effective for elderly and/or people with comorbidities, with adequate and early preparation, the government could quickly identify and locate individuals belonging to these categories. In the future, when vaccines are deemed safe and effective for children, adolescents and/or pregnant mothers, the government will be well prepared to administer vaccines to these subpopulations. Such capacities are yet to be tested as COVID-19 vaccination is being rolled out.

- 102.** The first batches of vaccines had been prioritized for healthcare workers (1.5 million), public administration, and law enforcement officials, and other essential workers in close contact with the society at large. The elderly have also received prioritization in the ongoing second phase of vaccination. For these sub-population groups, the government will rely on their centralized databases such as SISDMK (Health Human Resource Information System/*Sistem Informasi Sumber Daya Manusia Kesehatan*) as well as civil registry databases. However, the GoI needs to make sure that these databases are updated through coordination with respective sub-national governments. This also includes modalities for covering sub-populations who are not included in the civil registry databases. Further, MOH's COVID-19 technical guideline does not further specify vulnerable sub-groups, particularly those considered as vulnerable, disadvantaged, underserved and/or impacted beyond socio-economic dimensions and how to identify these groups.
- 103.** There are several existing specialized databases such as MoHA Population Administration Information System (*Sistem Informasi Administrasi Kependudukan* or hereafter SIAK), Ministry of Social Affairs (MoSA) Unified Database for Social Protection (*Data Terpadu Kesejahteraan Sosial* or hereafter DTKS), Universal Health Coverage (*Jaminan Kesehatan Nasional* or hereafter JKN) register administered by BPJS, and various logbooks at Puskesmas and hospitals, each with different sets of information. These datasets are being consolidated into One Data Information System for COVID-19 Vaccination for the purpose of targeting and allocation. However, since there are likely inherent inconsistencies and potential errors in these data sources, vaccination database will likely carry over these inconsistencies and errors. Further, there are risks of fragmentation and misallocation since actual implementation will be decentralized, potentially relying on various population datasets.
- 104.** People who are not part of any government's registries or whose domicile do not match their administrative records may be excluded. This population may include, but not limited to, circular or seasonal migrants, homeless people and street children, transgender population, and isolated populations. Since the transmission is disproportionately high in urban areas, certain urban populations might also be inadvertently excluded from targeting and identification due to mismatch between their actual residential address and their administrative records. They include people living in informal settlements, newly arrived migrants who have not updated their administrative record, as well as seasonal and transient migrants (including migrant students). Other transient populations such transgender, homeless, and street children may even be missing from any governmental databases.
- 105.** The new draft of Ministerial Technical Guidance on COVID19 Vaccination will require the Civil Identification Number (NIK) as a pre-condition for vaccination, following guidance from the anti-corruption commission for due accountability for the use of vaccines²⁵. While NIK coverage has expanded up to 95 percent of adult population (above 17 years old), such a requirement may potentially prevent up to 4.9 million adults in Indonesia from being inoculated (SUSENAS 2019). Analysis of the National Socio-Economic Survey (SUSENAS) data and various studies show that populations without NIK are more likely among the poorest and living in underserved regions such as Papua and Maluku. They are also more likely to be coming from vulnerable groups such as

²⁵ <https://voi.id/en/news/25909/kpk-kirim-tim-untuk-tata-kelola-vaksin-covid-19>

people with disabilities, transgender, transient seasonal migrants, and indigenous communities who face structural and legal barriers to acquiring NIK and legal documentations. Instead of making NIK a prerequisite, vaccination programs and posts could be used as an entry point to identify and outreach those without NIK and facilitate their civil registration. The MOH is exploring such modalities to retain the requisite accountability against misuse of vaccines while also ensuring inclusive mechanisms to identify and register beneficiaries and this is also being included in the Program action plan (PAP).

- 106.** Measures to address exclusion errors are therefore critical understanding that there are likely loop holes in the existing One Data Information System for COVID-19 Vaccination. Such measures will need to be responsive and agile to inform vaccination planning due to limited availability of vaccines in the near and medium-term. KOMINFO and MOH is deploying Short Message Service (SMS) notification to target participants through which they can register (Health Minister's Decree No.HK.01.07/Menkes/12757/2020). Such registration is expected to be undertaken as early as possible to assess demand in particular localities to inform vaccination planning and quotas. The functioning of this system is yet to be observed as it is being expanded to include other target participants beyond health workers.
- 107.** A bottom-up database updating can also be activated by mobilising village apparatus/hamlets (i.e. RT/RW), village supervisory non-commissioned officers (Babinsa) and community cadres to update their registry at village or RT/RW level and/or the nearest *Puskesmas*. MoHA or provincial/district governments could initiate such updating by providing villages or RT/RW with an initial list of all individuals recorded to reside in specific areas from their databases (especially from SIAK). The updating should be inclusive, and it should register all individuals residing in their authority regardless of the stated domicile on their ID card (or the lack thereof). ²⁶the Anti-corruption Commission (KPK) found that 16.7 million individuals without NIK were registered in MoSA's DTKS, reflecting the significant discrepancies across government databases^[OBJ]. Although the updating is a basic responsibility of the village and RT/RW apparatus, it is usually conducted in a passive manner (through the so-called LAMPID form), that is waiting for individuals to report to the village office. For vaccination roll-out, the government needs to mobilise village and RT/RW staff to actively update the registry, by registering new-borns and newcomers, and removing dead and out-migrants from their lists. An active updation is not a new task as recently villages and RT/RW were also deployed to update the register for eligible beneficiaries for government social assistance as part of COVID-19 response.
- 108.** In circumstances where there is a discrepancy between government's consolidated roster of prioritized individuals with the actual number of people needing vaccination, a mechanism is yet to be established to reconcile the exclusion errors. The exclusion of eligible individuals could emerge not only from missing individual data but due to people's mobility between provinces or districts/cities. When an individual is administratively registered in one province but residing in another province, there are risks that they would not be able to access vaccination. Therefore, it is necessary to build a system where eligible individuals who are missing from both local and national registers could come forward and immediately be provided with the necessary vaccines. This may also require allocating extra vaccines to buffer against unaccounted additional needs as well as wastage.

²⁶ CNN Indonesia. 2021. "Temukan Masalah, KPK Pastikan Pantau Penyaluran Bansos." *Nasional*, January 6, Online edition, sec. National. <https://www.cnnindonesia.com/nasional/20210105204309-12-589911/temukan-masalah-kpk-pastikan-pantau-penyaluran-bansos>.

109. Furthermore, in case where vaccine hesitancy and/or refusal is still prevalent, and as vaccine supply improves in the future, there are possibilities of significant number of eligible individuals not showing up for vaccination. There needs a contingency measure to enable vaccine re-allocation to the next prioritized individuals to prevent expiration and/or other illegitimate misuse.

D.3.3 Equity and Accessibility

110. Free COVID-19 vaccination is technically available for every Indonesian citizen above 18 years of age, prioritizing those at high risks of acquiring and transmitting infection, or suffering from disproportionate morbidity and/or mortality due to COVID-19, with an objective to achieve herd immunity.

111. In addition to vaccine availability challenges and how the prioritization plan will work in practice, access inequity also stems from public safety considerations, logistical distribution constraints, health system readiness especially in lagging regions and exclusion from population databases. Individuals with certain medical conditions (i.e. severe co-morbidities), persons with recent COVID-19 infection and pregnant women are provided medical exemptions, for which detailed screening protocols are already provided in the Technical Guidelines of the MOH²⁷⁻²⁸. Access issues, such as where the health system itself is under-developed, can also create an equity challenge, particularly in lagging areas. Greater emphasis on understanding such access challenges and finding solutions to improve access to vaccines will be needed to ensure equity in vaccine access.

112. Distance to health facility can deter people living in areas where health facilities are scarcely placed from accessing vaccination. In these areas, a passive vaccination approach where individuals must travel a great distance to health facilities may incur a considerable transportation cost on the individuals that further deter them from getting vaccinated. People with disabilities especially with physical mobility challenges, including elderly, may confront accessibility issue even if distance to health facility is not a problem. It is therefore important to devise a plan to outreach these populations.

113. Cost may also be an issue not only in regards to transportation to health facility but also pertaining necessary test as part of vaccination screening requirement. PLHIV for instance need to take additional CD4 count test to be eligible for vaccination while people with comorbidities are encouraged to consult medical doctors before getting vaccination. Combined with the lack of testing facilities and accessibility issues, this may further incur cost and disincentivize people to be vaccinated. It is essential to facilitate prerequisite screening tests that are accessible and at an affordable cost, to ensure both the accessibility and safety of the vaccination. Individuals and communities who need specific screening test could be directed to certain facilities where they can access the required tests as well as vaccinations.

114. Understanding equity in access greatly rely on availability of documentation to enable systematic tracking and gap filling. Historically, administrative data on immunization are generally weak, with inconsistencies in administrative and survey data (up to 30 – 40 percentage points). Data are often distorted in transmission, with heavy reliance on reporting from delivery points, starting at the community level (*Posyandu, Polindes*) and use of different denominators across reporting levels.

²⁷ <https://promkes.kemkes.go.id/sk-dirjen-nomor-hk0202412021-tentang-petunjuk-teknis-pelaksanaan-vaksinasi-dalam-rangka-penanggulangan-pandemi-covid19>

²⁸ <https://covid19.go.id/masyarakat-umum/kelompok-lansia-komorbid-penyintas-covid-19-dan-ibu-menyusui-bisa-divaksinasi-ini-syaratnya>

Further, data are often handled manually, through a fragmented nature of MOH's information system components, leading to poor intake and quality of reporting due to administrative burdens.

D.3.4 Public Health Communication

- 115.** There are studies that suggest a significant number of people were hesitant to be vaccinated for reasons that can be considered as healthy scepticisms pertaining to the safety and efficacy of COVID-19 vaccines (Harapan et al. 2020, Indonesia High-frequency Monitoring of COVID-19 Impacts, WHO, UNICEF, ITAGI, MOH 2020). However, other reasons are reportedly to be founded on religious grounds. Further, scepticism around the existence of the virus may be fuelled by hoaxes and misinformation circulating in the media and the broader public. MOH has prepared a communication strategy as part of COVID-19 emergency response. However, its effectiveness is likely hampered by such hoaxes and misinformation, often exacerbated by changing policies, resulting in scepticism and public confusion. Furthermore, as there is little evidence that any COVID-19 vaccines will reduce infection and transmission, public communication regarding vaccines should include transparent message about what vaccines can and cannot do to prevent false sense of security among vaccinated individuals. Amid such potential public hesitation, the public communication strategy should adopt persuasive approaches to foster demand to the extent possible and hence, enable individuals to provide their consent prior to vaccination. An assessment of MOH's public health communication effectiveness is currently not available. Previous massive campaigns for vaccination have been done in the past as well, even though not at the scale COVID-19 vaccination requires. Indonesia has held Immunization Weeks (*Pekan Imunisasi Nasional*) as the GOI made mass immunization into a national movement that requires the involvement of and contribution from all. There have been several massive campaigns including the successful one to eradicate Polio (in late 90s) and more recently the local or regional mass immunization campaign to address outbreaks of vaccine-preventable diseases (Measles outbreaks and Diphtheria outbreaks in 2017 -2018). Public communications and education have been a critical component in these campaigns, and will also be important in the COVID-19 vaccination program. While there is an increasing trend of vaccine hesitancy to child immunization program in the country, especially in some geographical pockets that are known to have high(er) vaccine resistance or hesitancy, the GOI has adopted persuasive approach and modify the communication material to address identified factors of vaccine resistance or hesitancy. In this regard, there are news items quoting higher officials, even the President, that GoI is emphasizing primarily on a persuasive approach for COVID-19 vaccination as well.²⁹ Clear messages on the safety and effectiveness of the government-funded vaccines will be critical to foster and sustain demand as the GOI is planning a national roll-out.
- 116.** MOH needs to assess the above risk and seek public and individual buy-in through keeping the public informed. Therefore, based on the risk assessment, MOH must also build a communication strategy to educate and assure citizens, to engage mass media and religious leaders, and to solicit citizens' feedback. Such a strategy is lined with VRAF and VIRAT criteria about demand-creation for vaccination. The public communication strategy needs to include means for citizens to access updated information on the vaccines in an accessible manner, to be informed of the delivery service standards (on progress), to ask questions, convey concerns, and receive official responses in a prompt and credible manner. MOH also needs to provide a clear message on what COVID-19 vaccines can and cannot do based on available scientific evidence so as to not give false sense of security.

²⁹ <https://www.cnnindonesia.com/nasional/20210215132153-20-606363/fadjroel-jokowi-persuasif-dan-humanis-dalam-vaksinasi-covid>

- 117.** An accessible public complaint and grievance mechanism should also be set up and be informed to the public. Transparency requires measures to communicate with the public openly, clearly, accurately, and straightforwardly about the allocation, including any changes and modifications made during implementation. Specific strategies for communication with people with unique needs such as blind people, deaf, and children are required to ensure they receive the correct information. In addition, several categories of population (e.g. PLHIV, people with comorbidities) may also need additional information due to specific health risks and concerns as well as their needs to take additional tests as part of the vaccination screening process.
- 118.** At this moment, HALO Kemkes along with COVID-19 Hotline 119 have been the main channels within MoH through which members of the public could actively seek information and education regarding vaccines and vaccination plans. A team of 11 personnel have been mobilized for the call center. Additional training and reference materials are necessary to prepare agents to answer public queries and to refer other questions to the right sub-division(s) within MoH. Furthermore, MoH needs to strengthen coordination between relevant sectors as well as to establish a clear disposition protocol and pathways with other sectors and Health Offices at provincial and district/municipal levels. The protocol will include clarifying the types of complaints and queries that need to be expedited or to be diverted to other divisions in MoH or other institutions, or to be transferred to subnational units.

D.2.4 Hazardous waste management

- 119.** Persistent disparity between hazardous medical waste volume and the processing capacity in the country remains the biggest challenge in managing COVID-19 related waste in Indonesia, especially in the regions outside Java. According to MOEF,³⁰ a total of 1,662.75 tons of COVID-19 medical waste has been generated as of October 15, 2020. The total medical waste generated in the country has spiked around 30 percent, from 293.87 tons/day before the pandemic to currently around 382.03 tons/day from around 2,820 hospitals and 9,884 *puskesmas* in the country. Although the processing capacity has also been increased over the course of the pandemic,³¹ the additional capacities are mainly concentrated in Java. There are currently about 110 hospitals with licensed incinerators or autoclaves with the total processing capacity of 70.21 tons/day and 17 licensed third-party medical waste-processing facilities—more than half of these facilities are located in Java.³² The uneven presence of licensed medical waste facilities in Indonesia indicate areas of attention for the planning of additional facilities or alternatives for medical waste management. Similar circumstance is also observed in the distribution of licensed hazardous waste transporters, with 97 out of 140 licensed transporters are located in Java. The uneven distribution of the processing facilities and transporters is hindering the optimum implementation of medical waste management in the country. Based on the distribution and availability of medical waste processing facilities in Indonesia, it is evident that the waste processing facilities in the country are currently dominated by the use of incinerators. There are recommendations from several stakeholders on the use of other non-

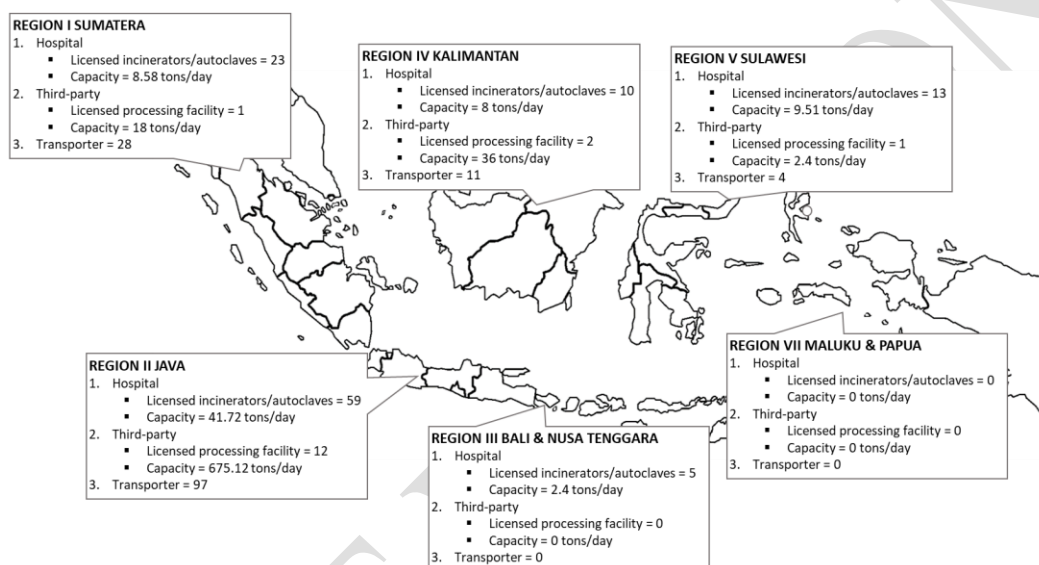
³⁰ Based on presentation by Environment and Forestry Ministry Director General for Waste Management presentation during National Appeal on Accelerating Medical Waste Management on November 13, 2020. The event was posted in MOH's Environmental Health website (<http://kesling.kemas.kemkes.go.id/videodetail/detail/43>), accessed on November 19, 2020.

³¹ Based on data from MOH, there were 82 licensed incinerators and 3 licensed autoclaves across 20 out of 34 provinces as of Dec 2019 with total capacity around 53.12 tons/day and 12 third-party processing facility with total capacity of up to 248.88 tons/day. The data presented during Medical Waste Management During COVID-19 Pandemic Webinar which was organized by Indonesia Hospital Association on April 1, 2020.

³² Information on licensed incinerators and autoclaves were based on MOEF data in April 2020, while the information on licensed thirdparty were based on MOEF data in October 2020. Both information were obtained in the opening presentation during National Appeal on Accelerating Medical Waste Management on November 13, 2020.

incineration technology, such as autoclaves, in managing the surge of medical wastes.³³ Similar recommendations are also shared by several stakeholders during ESSA consultation.

Figure 1. Distribution of medical waste processing facilities and transporters



120. In a bid to further increase the processing capacity, MOH has distributed additional four incinerators and four autoclaves to seven provinces in September 2020³⁴, while MOEF is also constructing five additional medical waste treatment facilities.³⁵ A roadmap to further increase hazardous waste processing capacity has also been prepared with a total of 32 incinerators are planned to be built across the country³⁶. To tackle the surge of medical waste during the pandemic and limited availability of processing facility, MOH and MOEF provided alternatives methods through the issuance of COVID-19 waste management guideline, which allows healthcare facilities to use their existing incinerators or autoclaves although the said equipments have not received licensed from MOEF. Discretionary measures for COVID-19 wastes disposal in burial pits are also allowed for facilities without incinerators, autoclaves or access to third-party waste handling—especially for the ones located in rural area. These discretionary measures are subjected to certain technical requirements³⁷ and coordination with the provincial- and/or district-level environmental agencies.

³³ Ministry of National Development Planning (Bappenas) and Environmental Engineering Alumni Truss Institute of Technology Bandung (2020), “Pengelolaan Limbah B3 Medis & Sampah Rumah Tangga Penanganan COVID-19”, Policy Brief. Ismawati, Y., Septiono, M.A., Paramita, D. (2021). “Pengelolaan Limbah B3 Medis di Indonesia dan pada Masa Pandemi”. Nexus3 Foundation

³⁴ WHO, in collaboration of UNDP, procured the incinerators and autoclaves (WHO COVID-19 situation report – 26, dated September 23, 2020). MOH through Directorate of Environmental Health coordinated the distribution of these equipments. The seven provinces are West Sumatra, DKI Jakarta, Central Java, Yogyakarta, East Java, Bali, and South Kalimantan.

³⁵ Based on presentation by Environment and Forestry Ministry Director General for Waste Management presentation during National Appeal on Accelerating Medical Waste Management on November 13, 2020. The five provinces are Aceh, West Sumatera, South Kalimantan, West Nusa Tenggara, and East Nusa Tenggara

³⁶ MOEF Pers Statement No.SP. 204/HUMAS/PP/HMS.3/5/2020 “KLHK Perkuat Regional untuk Respon Limbah Infeksius COVID-19”, online, accessed on November 20, 2020, http://ppid.menlhk.go.id/siaran_pers/browse/2477_. MOEF(2018), “Peta Jalan (Roadmap) Pengelolaan Limbah Fasilitas Pelayanan Kesehatan (Fasyankes)”, Jakarta.

³⁷ The requirements for incinerators and onsite burial pits are specified in MOEF Regulation No. 56/2015 and the COVID-19 waste management guidelines issued by MOEF and MOH.

- 121.** Despite these efforts, there are public concerns on the suboptimal management of COVID-19 wastes that could lead to improper disposal of the said waste—highlighting the importance of continuous support, supervision and enforcement.³⁸ The enforcement/supervision on waste management practices in Indonesia is carried out by the Provincial/District/Municipal Environment Agency. As part of an efforts to enhance coordination with the local environmental agency, MOEF issued circular letter no. S.401/PSLB3/PS/PLB.0/10/2020, reemphasizing the importance of supervision from local governments to ensure all medical waste are processed in accordance to applicable regulations and guidelines. MOH and MOEF have jointly organized training sessions³⁹ on COVID-19 medical waste management for healthcare facilities (including hospitals and *puskesmas*), Provincial/ District/ Municipal Environment Agencies and Provincial/District/ Municipal Environment Health Agencies, covering all 34 provinces in the country.
- 122.** It is expected that there will be an increase of medical waste volume from COVID-19 vaccination activities that could add more burden to the now-strained medical waste management system. MOH predicted that there are potentially about 7,579 tonnes of additional medical waste generated during COVID-19 vaccination campaigns.⁴⁰ Through the technical guideline on vaccination services, MOH provide guidance for healthcare facilities in mannging the wastes generated during the vaccination program. MOH, through the Environmental Health Directorate, has also held a socialization on COVID-19 vaccination waste management.⁴¹ Training and socialization should also be conducted in regular basis, targeting not only hospitals and *Puskesmas* but also local environment and health agencies. Continous cooperation and coordination between MOEF, MOH and local environment and health agencies are also imperative for the effective management of medical waste in the country.

D.3.5 Occupational Health and Safety (OHS)

- 123.** While the country has a regulatory framework and guidelines on OHS and IPC in place, the current strained capacity in the healthcare system is challenging its optimal implementation. Particular concerns are raised related to the availability of PPE for healthcare workers, in which the limited supply might potentially exposed the workers to COVID-19 infection.⁴² During the COVID-19 response, MOH used a forecasting tool developed by WHO – Essential Supplies Forecasting Tool (ESFT) to assess the PPEs needs across the country. The tools calculate the needs based on the spread and growth of the infection. A logistic dashboard to track the distribution has also been developed and in operation. The government has also worked with local industries to ramp up the PPE supply, with a significant increase in availability of local masks, gloves, and gowns reported since February 2020.⁴³ The implementation of COVID-19 vaccination will require additional PPE supplies for the healthcare workers and other personnel involved in the vaccination program. Logistical planning for vaccination considers the needs to assess and procure PPEs as prescribed in MOH’s technical guideline for COVID-19 vaccination implementation.

³⁸ BBC News Indonesia, “Virus corona: Limbah infeksius Covid-19 masih ditemukan di TPA, 'ada kelonggaran, pengabaian, dan tidak ada pengawasan’”, online, accessed on November 24, 2020, <https://www.bbc.com/indonesia/majalah-54640725>

³⁹ A total of 17 sessions have been conducted between 22 June to 15 July 2020, with 15,360 audiences attended the training.

⁴⁰ Based on presentation by Director of Environmental Health during the Socialization of COVID-19 vaccination waste management om January 13 & 14, 2021. The event was posted in MOH’s Environmental Health Channel (<https://www.youtube.com/watch?v=dXz8KshdsLA>), accessed on January 15, 2021

⁴¹ Socialization of COVID-19 vaccination waste management om January 13 & 14, 2021

⁴² Jakarta Post, “Most nurses died of COVID-19 were stationed in patient rooms”, online, accessed on December 10, 2020, <https://www.thejakartapost.com/news/2020/12/06/most-nurses-who-died-of-covid-19-were-stationed-in-patient-rooms-ppni.html>

⁴³ MOH, “Ketersediaan obat pasien COVID-19 terjamin di semua provinsi”, online, accessed on November 24, 2020, <https://www.kemkes.go.id/article/view/20092300001/ketersediaan-obat-pasien-covid-19-terjamin-di-semua-provinsi.html>

- 124.** MOH has developed training modules for healthcare personnel who will be involved in the vaccination program. Such training is aimed to upskill relevant healthworkers in implementing the vaccination program, including safe administration of COVID-19 vaccination, IPC measures, adverse event surveillance, etc. The training program has started since November 2020. As of January 13th 2020, a total of 23,016 healthcare personnel have attended the training, spread ⁴⁴ all 34 provinces.⁴⁵
- 125.** Healthcare workers have been identified as one of the priority groups to receive COVID-19 vaccines. Based on the country's COVID-19 vaccination roadmap, a total of 1,48 million healthcare workers in 34 provinces are the first in line to receive vaccination over the period of January to April 2021. Such prioritization is in accordance with the WHO SAGE recommendation, which is expected to provide protection to these workers as frontliners. However, since pregnant women and people with severe morbidities are currently excluded, efforts to promote safe-working conditions for healthworkers under these categories should be maintained.
- 126.** A maximum daily quota has been established under the COVID-19 technical guideline. This is expected to minimize disruption to other health services during the vaccination program and prevent influxes of people which present public health risks. Such daily quotas will also help avoid the already long work hours and overwork, leading to fatigue, which is one of the concerns that has been raised over the course of the pandemic.

D.3.6 Public Health and Safety related to Vaccine Quality and End-to-End Supply Chains and Logistics Management Systems

- 127.** Logistic management system, including cold chain infrastructure and equipment, is critical to maintain vaccines quality from the time they are being manufactured to the point of administration. MOH Regulation no. 12/2017 on Immunization Implementation outlines the types of cold chain infrastructure and equipment needed at the provincial, district and facility levels, as well as the mandates for each stakeholder in the planning and implementation of the vaccination program. The regulation divides the cold chain infrastructures into three categories: 1) Storage (e.g. cold room with temperature between 2° to 8°C, freeze room with temperature between -25° to -15°C, etc.); 2) transportation (e.g. cold box, cool pack, etc.); and 3) temperature monitoring (e.g. thermometer, thermograph, etc.), and also provide overall guidance on its planning (capacity assessment), financing, and distribution. Requirements on the standard operation and regular maintenance for each of the cold chain equipments are also set in the regulation.
- 128.** Vaccine and logistical distribution will be monitored through an electronic system for logistics monitoring called SMILE (*Sistem Monitoring Imunisasi dan Logistik Secara Elektronik*). The AF seeks to enhance GoI's logistic management system by upgrading the cold chain system required to meet the globally accepted quality standards including remote temperature monitoring deployed in the vaccine cold chain storage and distribution as per cold chain upgradation plan, including the introduction of track and trace technologies (GPS-enabled monitoring in select locations).
- 129.** MOH in coordination with Provincial and District/Municipal Health Offices is currently assessing the existing cold-storage facilities, their quality and specifications, as well as distribution across regions. This will inform requisite logistical requirements as part of COVID-19 vaccination planning. Additional logistics have been entrusted to a State-owned Enterprise (SOE), BioFarma which will use hired capacity from other pharmaceutical SOEs and companies, such as Unilever.

⁴⁵ Data taken from Directorate of Immunization Services presentation on COVID-19 vaccination program implementation, presented on January 14, 2020.

No infrastructure is being built under the government program and not under the World Bank's financing. As of December 2019, routine vaccinations take up 35 percent of the current total cold storage capacities. 65 percent is estimated to be available and accommodate both regular and COVID-19 vaccination until 2021. It is expected that the GoI will procure additional 449 refrigerator units in 2020 and 1028 units in 2021. MOH is currently assessing the country's cold chain with technical support from the Clinton Health Access Initiative (CHAI). As of January 2021, a total of 13,219 health facilities out of 19,792 facilities have submitted their self-assessment of vaccination readiness through P-Care and were considered ready.

130. Vaccine requirements are likely to vary. Potential vaccines need to be transported and stored in cold-storage facilities with different temperature requirements. Due to logistical constraints, only vaccines with feasible, low-cost distribution and logistics and longer shelf-life are likely to be procured. Vaccines requiring ultra-low temperature for their transportation and storage, such as those from Pfizer and Moderna, if procured, will likely be distributed in urban centers where there are limited logistical constraints. Furthermore, Pfizer vaccines are known to have shorter shelf life after they are taken out of their ultra thermal shippers⁴⁶, making it important to distribute the vaccines as fast as possible.
131. At the delivery point, vaccines should be administered by trained healthcare workers. Considering the disparity of healthcare capacity across regions, areas with low ratios of healthcare workers per population in remote regions, particularly in Eastern Indonesia, potential constraints may be anticipated with the required outreach and administration of the vaccines in these regions. MOH is rolling out a series of workshops targeted to healthworkers administering COVID-19 vaccination. A total of 18,008 participants across 34 provinces have been trained as of 9th January 2021. The majority of whom are from urban centers where the pandemic hit the worst. Such training is currently on-going, with potential adjustments to accommodate future developments of COVID-19 vaccines.
132. A national COVID-19 vaccination program is a massive undertaking that requires the deployment of a high number of healthcare workers. At the same time with the rate of infection still surging, there is a considerable strain on the healthcare system to respond to increasing demand for hospitalization. MOH needs to ensure that adequate resources and personnel are secured to avoid any major disruption to other lines of healthcare services including COVID-19 Tracking, Testing and Treatment (3Ts). Reducing the rate of transmission and hospitalization through other existing measures (physical distancing and travel restrictions) may be needed prior and during vaccination roll-out.

D.3.7 Feedback and Grievance Mechanism

133. Multiple channels have been utilized to accommodate grievances and inquiries related to COVID-19 emergency response, notably HALO Kemkes Contact Center and 119 Hotline Service. These channels are being operated by different departments within MOH, with HALO Kemkes (calls, text, email, letter, and social media), operated by the Communication Bureau and 119 Hotline operated by the Directorate of Referral Services. The same channels are anticipated to be retained for the COVID-19 vaccination roll out. However going forward, it is necessary to harmonize the different roles of these two channels and to strengthen their complementary and their operational interaction. Furthermore, HALO Kemkes and 119 Hotline are not the only existing FGRM channels managed by MOH. Other platforms such as LAPOR (managed by KSP) and through Hotline Pengaduan

⁴⁶ Pfizer-BioTech, "COVID-19 Vaccine U.S. Distribution Fact Sheet | Pfizer," November 2020, https://www.pfizer.com/news/topics/covid_19_vaccine_u_s_distribution_fact_sheet.

Ombudsman as well as a range of local hotline services can be mobilised to receive complaints from citizens. It is still unclear how these existing channels work and interact with each other. Strengthening the coordination and clarifying the operational interaction protocols between these channels will be crucial to ensure that any complaints received by any of these channels, national or local, are responded to adequately and quickly. A smooth interaction between various feedback and grievance channels will also ensure that complaints as well as subsequent resolution and resettlement are well documented and evaluated.

134. From the compiled data of complaints handling 1 January 2020 -30 September 2020, the recorded complaints for MOH's Inspectorate General (*Inspektorat Jenderal*) overwhelmingly came from emails (none from calls or text and only one from social media). Most of the complaints were deemed to be outside the purview of MOH's Inspectorate General and there was no further documentation of the process and the outcome of the complaint redress once it was dispatched to relevant organizations. Based on HALO Kemkes's SOP, citizens are also required to input their personal data in the system before their complaints are being handled. This requirement may provide further barriers for citizens to provide feedback and convey their grievance. There is a need to strengthen the process of redress and resettlement of grievances related to COVID-19 between different channels within and beyond MOH, especially on aspects related to back-end processing of grievance, redress and settlement.
135. On January 12, 2021 BPOM has issued EUA for SinoVac vaccines, followed by Astra Zeneca in March 2021, allowing for the commencement of the first phase of the vaccination campaign specifically for healthcare workers. It is highly likely that any COVID-19 vaccines will be rolled out using Emergency Use Authorization (as per Presidential Regulation on COVID-19 Vaccination). Therefore, their long-term efficacy and side-effects are not fully known. Some adverse effects may be exceedingly rare and are undetected during clinical trials that involve tens of thousands of individuals. It is crucial then to set up a system to closely monitor vaccinated individuals. Indonesia has a mechanism in place to detect any adverse events of basic immunization programs. It is envisioned that the COVID-19 vaccination will utilize the same mechanism. However, given that COVID-19 vaccination is a massive new undertaking with the goal to inoculate most adult population to reach herd immunity, it is important to strengthen the capacity of the existing system to receive and respond to any complaints related to side and adverse effects. Existing channels of public communication (i.e., HALO Kemkes, 119 hotline service, Ombudsman and LAPOR) must also be widely made accessible to accommodate reporting of vaccination adverse events and a clear protocol to refer individual complaints immediately. Going forward, the assessment also recommends deployment of random checks and follow-up across different population groups (aggregated by sex, age, socio-economic status and other risks factors) following vaccination to assess their conditions, identify any side-events (from light to severe), and provide treatments whenever necessary. Comprehensive and accurate documentation of these cases will be essential for future improvement of available vaccines, their distribution plans and the overall Program implementation.

D.3.8 Data and Privacy

136. The development and use of vaccination registry should only be used for vaccination purposes and individual privacy should be protected. Individual identifying data should only be accessible to officials and workers associated with the vaccination and should not be shared with other parties. On the need for data and privacy protection, MOH's Pusdatin is governed by ISO 27001 on Information Security Management System. However, system capacities for data and privacy protection under a national scale COVID-19 vaccination remain to be seen. While some features, such as smart checking to only grant access to only authorized individuals and integrity pacts, are

included in the overall system, MOH's ability to monitor may be limited since data entry points are located at the sub-national level.

137. Under the PforR, the extent of personal data being shared and collected throughout the vaccination process should adhere to the minimum standard and purposive limitation of individual data privacy in line with the General Data Protection and Regulation (GDPR), which is the main reference for the Personal Data Protection Bill. No information irrelevant to vaccination programs could be shared and/or collected. The development and use of the population database registry should only be used for vaccination purposes and individual privacy should be protected. Individual identifying data should only be accessible to officials and workers associated with the implementation of vaccination and should not be shared with other parties without consent from authorities.
138. Based on public consultations, several community-based organizations raised the concerns of privacy related to individual status as people living with HIV (PLHIV). The vaccination procedures require PLHIV to disclose their status and to present their latest CD4 count (to be eligible the CD4 count should not be lower than the prescribed threshold). However, PLHIV may potentially face undesired implications and risks when disclosing their status. Fear of stigma, discrimination, and potential socio-economic repercussions are some of the deterrence factors, which potentially discourage disclosure of health information and may present health risks due undisclosed comorbidities and lack of access to proper health screening, such as CD4 count. It is important to ensure that all involved personnel will uphold and guarantee the confidentiality of such disclosure. Vaccination should also be provided in a safe space and manner where PLHIV can disclose their status without the fear of being overheard.

D.3.9 Roles of Military and Security Forces

139. Under the national COVID-19 vaccination program, the police force has been involved to provide additional capacities to provide security services for vaccine distribution logistics at the provincial level (Minister of Health letter no. SR.02.06/II/346/2021). MOH has also requested additional capacities of medical staff (i.e., doctors and vaccinators) at health facilities owned by the National Police Force designated as vaccine administration points (MOH Secretary General Letter no. SR.02.06/C.II/558/2021). Military involvement may also be engaged as indicated in the draft manual for COVID-19 vaccination. The GoI does not envisage involvement of non-medical personnel from the military and police force for the purpose of COVID-19 vaccine delivery. Under this circumstance, while risks related to Sexual Exploitation and Abuse/Sexual Harassment (SEA/SH) as a result of involvement of military and security forces are expected to be low since passive surveillance at vaccination posts is available, relevant mitigation measures with regards to public communication, awareness of respectful environment for the purpose of COVID-19 vaccination and access to FGRMs are warranted under the Program.

E ENVIRONMENTAL AND SOCIAL RECOMMENDATIONS AND ACTIONS

- 140.** The recommended measures (on the following page) has been shared with MOH, with some pending actions currently being negotiated with MOH. The proposed action plans correspond to each of the area of concern under the ESSA addendum. The draft ESSA addendum report has been disclosed with Executive Summary and Environmental and Social Action Plans circulated to stakeholders consulted in Bahasa Indonesia. Further consultations are being organized with relevant stakeholders prior to the closing of the appraisal. The ESSA addendum, along with its proposed action plans will be finalized and re-disclosed following negotiations and prior to the Board approval.
- 141.** Relevant environmental and social action plans under the parent PforR remain valid, with enhancement measures recommended as part of the ESSA addendum. The World Bank will undertake periodic monitoring of the progress of the proposed environmental and social action plans. Such monitoring will be part of joint-regular implementation support missions between MOH and the World Bank and DLI verification processes by independent verifiers (i.e. Finance and Development Monitoring Agency or hereafter BPKP). Technical support for the implementation of the proposed action plans will be provided on a need basis at the request of MOH.

Table 6: Environmental and Social Action Plans

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
Population targeting, social inclusion and equity							
1.	<p>Building on the MOH’s Technical Guideline as issued through the Decree of Directorate General of Disease Control and Prevention of MOH (HK.02.02/4/423/2021), define and implement a protocol for bottom-up enrolment/registration to complement the top-down One Data for COVID-19 Vaccination (<i>Sistem Satu Data COVID-19 Vaksinasi</i>) from the lowest level of government, including a pathway for individuals to report their eligibility in case they are excluded despite their eligibility.</p> <p>MOH shall initiate a dialogue with the Ministry of Home Affairs (MoHA) for the development of an inclusive vaccine registration mechanism for individuals without NIK.</p> <p>MOH shall ensure access to and allocation of Program benefits in a fair, equitable and inclusive manner, taking</p>	<p>Directorate of Surveillance and Health Quarantine (Dit. SKK), Immunization Sub-division; Center for Health Data and Information (Pusdatin)</p>	<p>Sub-set of DLI# 13</p>	No	N.A	<p>Prior to Phase 4 (scale up to the general population)</p>	<p>An MOH’s circular on bottom-up registration issued and disseminated. The relevant protocol to be incorporated in the COVID-19 Technical Guideline once available.</p>

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	into account the needs of individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable in line with WHO SAGE Values Framework for the Allocation and Prioritization of COVID-19 Vaccination.						
2.	Develop and implement throughout the Program, a human resource strategy in line with WHO's Interim Guideline on Health Workforce Policy and Management in the Context of the COVID-19 Pandemic Response to ensure the availability of human resource for COVID-19 vaccination and non-COVID-19 essential health services in lagging and underserved regions.	MOH's Center of Health Human Resource Planning and Use (Pusrengun), Center of Education for Health Human Resource (Pusdik), Council of Health Human Resource (KTKI)	Sub-set of DLI#12 .1	No	N.A	By July 31 st 2021	An HR strategy to ensure availability of HR for COVID-19 vaccination and non-COVID-19 essential health services in lagging and underserved regions
Public health communication strategy and stakeholder engagement							
3.	Enhance the existing MOH's Communication Strategy in line with WHO Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response .	Directorate of Health Promotion (Promkes), Communication Bureau (Rokomyanmas) Directorate of Surveillance and	Sub-set of DLI #9.1	No	N.A. (to be re-assessed during implementation)	Enhancement of MOH's COVID-19 Communication Strategy prior to Phase 4 (scale up to the general population) and is	Improved COVID-19 Communication Strategy addressing specific elements in the action plan.

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	<p>and WHO Vaccine Safety Events: Managing the Communications Response in view of promoting social inclusion and social acceptability of the GoI's vaccination program through:</p> <ul style="list-style-type: none"> - Develop inclusive messages and outreach strategy for population groups that are facing barriers to access information marginalized population groups; - Disseminate information regarding the vaccination plans including prioritization, bottom-up enrolment/registration process, Feedback Grievance Redress Mechanism; Create demand and use persuasive approaches, by emphasizing benefits of vaccination and addressing misinformation - Be inclusive and sustained stakeholder engagement - Monitor vaccine acceptance/hesitancy, misinformation, and implementation of non- 	Health Quarantine (Dit. SKK), Immunization Sub-division,				implemented throughout the Program implementation	

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	pharmaceutical interventions.						
4	Develop, and implement throughout the Program, channels of information such as a public dashboard where public can monitor the subnational allocation of vaccines and the number of vaccinated persons with information on how to report mismanagement	Directorate of Surveillance and Health Quarantine (Dit. SKK), Immunization Sub-division	Sub-set of DLI #9	No	N.A	Prior to Phase 4 (scale up to the general population)	Information on COVID-19 vaccination made available to the public in an accessible and inclusive manner
Vaccine safety and consent							
5.	On this issue, the previously proposed PAP action stands deleted and a covenant has been incorporated in the draft legal agreement. <i>“the Borrower shall carry out the Program in conformity with appropriate administrative, technical, financial, economic, environmental and social, and public health standards and practices, including best practices in public vaccination.”</i>						
6.	Enhancement of COVID-19 pharmacovigilance measures including: <ul style="list-style-type: none"> • Bottom-up surveillance for Adverse Events following Immunization (AEFI) and FGRM; • Relevant capacity building for vaccine administrators on relevant communication and handling of AEFIs; • Procedures in place for AEFI response, including medical treatments and compensations 	Directorate of Surveillance and Health Quarantine (Dit. SKK), Immunization Sub-division	DLI #14	Yes	Bi-annual progress reports throughout implementation	As part of the PforR implementation	Implementation of pharmacovigilance, including through a bottom-up/ community based process is reported through administrative data/ reports.

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	Note: vaccine safety through end-to-end supply chain and logistic management has been addressed as part of DLI #11						
Handling of grievances							
7.	<p>Enhance the existing Feedback and Grievance Redress Mechanism (FGRM) through MOH's Hotline for COVID-19 (119) and HALO KEMKES. Enhancement measures include incorporating a bottom-up pharmacovigilance reporting, synchronization with multiple FGRM channels within and outside MOH to enable systematic monitoring, tracking, follow-up and settlement.</p> <p>The FGRM will be publicized, maintained and operated to receive and facilitate resolution of concerns and grievances in relation to the Program, promptly and effectively, in a transparent manner that is culturally appropriate and readily accessible to all Program-affected parties, at no cost and without retribution, including</p>	<p>Directorate of Referral Services (PKR), Directorate of Surveillance and Health Quarantine (Dit. SKK), Directorate of Health Promotion and Community Empowerment (Promkes), Communication Bureau (Rokomyanmas)</p>	Sub-set of DLI #9.1	Yes	throughout implementation	As part of PforR Implementation (<i>existing FGRM channels are in place</i>)	A FGRM enhancement action plan for COVID-19 vaccination prepared and implemented jointly with relevant departments within MOH and other relevant stakeholders

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	concerns and grievances filed anonymously.						
Individual data privacy particularly with regards to individual targeting and tracing							
8.	Develop a guideline to protect data privacy and confidentiality (i.e., smart checking, non-disclosure agreement, integrity pacts for data administrators) in line with good practices in personal data management.	Center for Health Data and Information (Pusdatin)	N.A. (building on an earlier action plan)	No	N.A	A guideline for privacy and data confidentiality measures within Pusdatin is a condition for effectiveness and implemented throughout the Program	A guideline for privacy and data confidentiality measures in line with good practices in personal data management within Pusdatin in place and implemented.
Pollution Prevention and Management							
9.	Conduct/update rapid assessment on current capacity/practice in hospitals and primary healthcare facilities participating in the vaccines delivery to manage medical waste and the expected volume of waste generated during the vaccination campaign.	Directorate Environmental Health;	N.A.	Yes	Throughout Program implementation	By June 30 th and monitored throughout Program implementation	Rapid assessment for hospitals and primary healthcare facilities participating in the vaccines delivery for the Program has been conducted and continuously monitored throughout Program implementation
10.	Update and implement protocol to ensure that the acquisition, storage, transportation and handling of vaccines (including, ultra-cold chain management) is conducted in a safe manner, and adequately manage and dispose of health care wastes	Directorate Environmental Health Directorate of Surveillance and Health Quarantine (Dit. SKK),	Subset of DLI #11.2	No	N.A.	Protocol is updated in the technical guidelines 30 days after effectiveness and implemented throughout the	Protocol to ensure safe management of vaccines purchase, storage, transportation and handling, as well as waste from vaccination activities are updated and implemented

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	from vaccination activities in line with WHO guideline on safe management of wastes from health-care activities and WHO technical brief on water, sanitation, hygiene and waste management for COVID-19	Immunization Sub-division DG of Pharmacy and Medical Equipment				Program implementation	
11.	Provide training to healthcare workers, local environment agency, local health agency on the management of COVID-19 vaccine wastes in line with WHO guidance on Safe Management of Wastes from Healthcare Activities and WHO technical brief on water, sanitation, hygiene and waste management for COVID-19 .	Directorate Environmental Health	N.A.	Yes	Based on needs	Ongoing	Number of training sessions delivered
Occupational Health and Safety							
12.	In conjunction with PAP 2, assess and procure additional PPEs needed for COVID-19 vaccination program in line with WHO guideline on Rational Use of Personal Protective Equipment for Coronavirus Disease 2019 (COVID-19) .	The Center for Health Crisis of MOH	N.A.	No	N.A	Assessment as condition for effectiveness, and procurement throughout the Program implementation	Additional PPEs needed for COVID-19 vaccination has been assessed, procured, and distributed to designated vaccine facilities
13.	Update and implement protocols on occupational health and safety measures during vaccination activities (including infection	Directorate of Surveillance and Health Quarantine (Dit. SKK),	No	No	N.A	Protocol is updated in technical guidelines 30 days after	Protocol is available and up to date and widely disseminated

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	prevention and control and personal protective equipment) and labor management (including working conditions) in line with WHO Infection prevention and control (IPC) principles and procedures for COVID-19 vaccination activities.	Immunization Sub-division				effectiveness and implemented throughout Program implementation	
14.	Provide training to healthcare workers who are involved in vaccination program, including on safe management of vaccines per the guideline under PAP 10; Infection and Prevention Control (IPC) measures during vaccination and PPE usage in line with WHO Infection prevention and control (IPC) principles and procedures for COVID-19 vaccination activities.	Directorate of Surveillance and Health Quarantine (Dit. SKK), Immunization Sub-division	Subset of DLI # 12.2	Yes	Based on needs	Ongoing	Number of training sessions delivered through modalities suitable for the types of skills being trained
Community Health and Safety							
15.	Monitor application IPC measures in COVID-19 vaccine administering facilities and adherence to handling of vaccine waste management, including requisite training to vaccine administering facilities in line with the following WHO guidelines: Safe	Directorate of Surveillance and Health Quarantine (Dit. SKK), Immunization Sub-division	No	Yes	Bi-annual reporting	Throughout Program implementation	Monitoring and training delivery reports

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	<u>Management of Wastes from Healthcare Activities, Technical Brief on Water, Sanitation, Hygiene and Waste Management for COVID-19, and Infection Prevention and Control (IPC) Principles and Procedures for COVID-19 Vaccination Activities.</u>						
Respectful Workplace Environment							
16.	Issue a circular on ensuring respectful environment for the purpose of COVID-19 vaccination to the sub-national governments along with culturally appropriate media for public messaging (i.e., pamphlet, poster, etc.) that contains FGRM channels accessible to the public.	Directorate of Surveillance and Health Quarantine (Dit. SKK), Immunization Sub-division, Directorate of Health Promotion and Community Empowerment, Communication Bureau (Rokomyanmas)	No	No	Bi-annual	Prior to Phase 4 (scale up to the general population)	A circular on ensuring respectful environment along with relevant media for public messaging available and disseminated.

F ENVIRONMENTAL AND SOCIAL RISK RATING

142. Similar to the parent PforR, the environmental and social risk under the AF is deemed to be **substantial**. There is a likelihood the Program would lead to some E&S consequences, but the risks are predictable and can be managed through risk management measures. The current strained capacity in responding to the pandemic may contribute to the possibility of the Program may not achieve its environmental and social operational objectives or sustain the desired environmental and social outcomes.
143. Risk areas of concern considered under the AF are aligned with the Vaccine Introduction Readiness Assessment Tool (VIRAT)/Vaccine Readiness Assessment Framework (VRAF) as recommended by the World Bank, WHO and UNICEF. These include a) population targeting, social inclusion and equity; b) public health communication and stakeholder engagement; c) individual rights to vaccination and consent, particularly amongst population groups who are sceptical and/or refuse vaccination; d) handling of grievances, including pharmacovigilance measures to monitor adverse events; e) individual data privacy; e) environmental pollution and community health and safety issue related to the handling, transportation and disposal of COVID-19 vaccine wastes (i.e. syringes, vials, PPEs, etc.); f) vaccine safety related to end-to-end supply chain and logistics management systems for effective vaccine storage, handling, and stock management – including rigorous cold chain control; g) Occupational Health and Safety (OHS). Proposed environmental and social action plans under the AF are aimed to enhance existing systems and measures to correspond to these areas of concern.
144. GoI's vaccine prioritization is generally aligned with the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and Indonesian Technical Advisory Group on Immunization (ITAGI). COVID-19 vaccination seeks to focus on reduction of direct morbidity and mortality and maintenance of most critical services, while considering reciprocity towards groups that have been placed at disproportionate risks to mitigate consequences of this pandemic (i.e. frontline health workers). Adults of 18 – 59 age bracket will receive priority for vaccination with the view of availability of vaccines as well as safety. Further, by vaccinating more socially mobile and economically active populations, the GoI anticipates reaching herd immunity more quickly. There are about 181.5 million people to be vaccinated (or 67 percent of the population), requiring 426 million doses of vaccines with a double-dose regimen and 15 percent wastage.
145. There are risks of social refusal for vaccinations and some sub-national governments are contemplating to introduce sanctions for people who refuse to be vaccinated. However, whether and how sanctions will be enforceable is unclear and is a matter of debate since there are no guidelines and/or operational manuals to enact relevant provisions on sanctions in the regulation. Under this PforR, public health communication for COVID-19 vaccination should emphasize persuasion. A legal covenant has been agreed to ensure that the GOI carries out the Program in conformity with, inter alia, best practices in public vaccination. Provisions for medical exemptions are also already included in the technical guidelines of the MOH, which also forms part of the screening by health workers prior to each vaccination. It will be important to monitor the implementation of the vaccination program to ensure good practices are being adhered to.
146. Disparity between hazardous medical waste volume and the processing capacity remains the biggest challenge in managing COVID-19 related wastes in Indonesia, especially in the regions outside Java. More than half of licensed medical waste processing facilities and transporters are located in the island. It is expected that additional medical waste generated from COVID-19 vaccination activities may add more burden to the now-strained medical waste management system. MOH and MOEF has led various efforts in improving medical waste management in the country, these include distributing and constructing additional medical waste processing equipment, developing and disseminating COVID-19 waste management guidelines, and conducting training and webinar for

healthcare workers and local environment/health agencies. Additional guidance on management of waste during vaccination activities is already included in the recently published vaccination technical guideline. Continuous interagency cooperation in addressing concerns related to medical waste management and its supervision remains critical in ensuring the proper implementation of relevant regulations and guidelines.

- 147.** There is a risk COVID-19 exposure to healthcare workers during vaccination activities. Specific measures pertaining to OHS requirements during vaccine administration are included in the MOH's technical guideline for COVID-19 vaccination. The measures include a) priority vaccination for those administering vaccination, including supporting personnel; b) application of health and basic hygiene protocols, and use of PPEs, c) social distancing requirements, d) fatigue management by capping daily quotas. Additional PPE supplies for healthcare workers and other personnel involved in the vaccination program is also needed. Logistical planning for vaccination, which consider the needs to assess and procure PPEs, is also prescribed in MOH's technical guideline. A system to monitor the distribution of vaccines and other logistics, including PPEs, have been developed. The implementation of this monitoring system is critical to ensuring healthcare workers are properly equipped with PPE so as to minimize exposure risk. Prioritizing healthcare workers to receive the vaccines is expected to provide infection protection to these workers as frontliners.
- 148.** While it is acknowledged that under the pandemic situation the government will need to thread and balance carefully the human wellbeing objective (of reducing COVID 19-related deaths and morbidity) and the objective of economic recovery especially in making decisions about prioritized groups, there are concerns that the government may focus on economic recovery more than public health goal. There may be trade-off but there are also ways to reconcile the two objectives. Prioritizing healthcare workers, essential sectors, and vulnerable populations may help to reduce the number of deaths and severe illnesses, to ease the strain on the health system, and at the same time contribute to economic recovery.
- 149.** People in remote areas, including vulnerable groups such as Indigenous Peoples and marginalized groups such as people with disabilities, LGBTQI, religious minorities may face constraints in accessing COVID-19 vaccines despite their willingness to be vaccinated. The assessment acknowledges that access equity remains low, with disparities in geographical access, health worker distribution, and quality of services, particularly in Eastern Indonesia. People who are not part of any government's registries or whose domicile do not match their administrative records may be excluded. This population may include, but not limited to, circular or seasonal migrants, homeless people and street children, transgender population, and isolated populations. As the transmission is disproportionately high in urban areas, certain urban populations might also be inadvertently excluded from targeting and identification due to mismatch between their actual residential address and their administrative records. They include people living in informal settlements, newly arrived migrants who have not updated their administrative record, as well as seasonal and transient migrants (including migrant students). Measures to address exclusion errors are therefore critical understanding that there are likely loop holes in the existing One Data Information System for COVID-19 Vaccination. Such measures will need to be responsive and agile to inform vaccination planning due to limited availability of vaccines in the near and medium-term.
- 150.** Gender inequalities may likely exacerbate access to healthcare. These may stem from access issues (i.e. access to information, services, and trade-offs with domestic responsibilities) as well as socio-cultural barriers where men may get prioritization. Further, since pregnant women are not eligible for vaccination, it is not clear with regards to their access following labor and/or whether there will be prioritization for women who expect pregnancy prior to vaccination. Understanding that COVID-19 vaccination may take up precious health resources, which are already strained particularly in lagging regions, there are risks that such a program may disrupt the regular maternal

health services, including ante- and post-natal care. Women-friendly and safe spaces for vaccine delivery are also an important element to ensure well-being of women during vaccination.

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ANNEX 1: Summary of DLIs for the Additional Financing

Disbursement Linked Indicators	Disbursement Linked Results	Baseline	Target including Updated Target	Notes/Formula
(1) DLI #1: Specific additional measures to support and compensate health professionals for added COVID-19 related workload and risk are implemented	DLR #1.2: The Implementation Guidelines for Health Professionals' Support for COVID-19 response remain in place and the payment of benefits has been continued in 2021.	0	The policy to provide incentives and death compensation is continued for all calendar quarters in 2021.	Value: US\$ 40 million Scalable/monthly payment: Unit Price: \$3,333,333 per Calendar month in 2021 that the Guidelines for Health Professionals' Support remain in place and the payment of benefits has been continued.
(3) DLI #3: Increased capacity for patient isolation and medical care	DLR #3.3: In each calendar quarter of 2021, at least 90% of hospital claim payments for treating COVID-19 patients have been received by the hospital within 10 business days after the receipt of the verification for such claims by MOH. DLR # 3.4: Number of COVID-19 patients with moderate to severe illnesses that receive hospitalization and have their claims paid for by the MOH, on or after the date of signature of this Agreement.	0	More than 90% for each quarter 200,000	Value US\$ 10 million (Unit Price: \$2,500,000 for every calendar quarter of 2021 that the Target is met. (Prior result for the first calendar quarter of 2021) Target: In each calendar quarter of 2021, at least 90% of hospital claim payments for treating COVID-19 patients have been received by the hospital within 10 business days after the receipt of the verification for such claims by MOH Value US\$ 60 million. Scalable. Unit Price: \$300 for each claim paid for COVID-19 patients receiving free hospital treatment, up to the Target.

(4) DLI #4: Health facilities' readiness for emergency response	DLR #4.2: 2000 additional high care beds in existing medical facilities outside Jakarta are equipped to manage severe respiratory illnesses pursuant to the National Protocol (of which at least 50% are equipped with ventilators)	0 in May 2020 Current value is 2,355	2,000 new beds over and above the current achievement.	Scalable; Value: US\$ 50 million Unit Price: \$25,000 per high care bed fully equipped pursuant to the National Protocol, up to 2,000 new beds over and above the Baseline. Current value: 2,355 is the # of high care beds outside of Jakarta 2020
(7) DLI #7: Installed capacity of quality-assured COVID-19 confirmatory tests per day	DLR 7.3 Borrower has tested 1 person per 1000 population per week (including polymerase chain reaction (PCR), rapid molecular and rapid antigen tests) in the Additional Provinces.	5 Provinces	20 Provinces	Total value: US\$ 45 million Scalable, Unit Price: \$3,000,000 per new Additional Province where 1 person per 1000 population per week is tested up to the Target. Target: 15 Additional Provinces Note: The five provinces as the baseline; DKI Jakarta, Daerah Istimewa (DI) Yogyakarta, Kalimantan Timur, Kalimantan Selatan, Kalimantan Utara.
	DLR 7.4 The Borrower has introduced Rapid Antigen Testing in all Provinces.	0 provinces	34 provinces	Value US\$ 51 million; Scalable; Unit Price: \$1,500,000 per Province that has completed the first 10,000 Rapid Antigen Testing up to the Target.
	DLR 7.5 The Borrower is undertaking regular genomic surveillance for variants of the COVID-19 virus.	0	At least 300 samples for every calendar semester from January 2021 to June 2022.	Value US\$ 15 million; Scalable; Unit Price: \$5,000,000 per calendar semester in which at least 300 samples are tested for genomic variants of the COVID-19 virus during the Target period. Target: 300 tests per calendar semester during January 2021 to June 2022

<p>(9) DLI # 9 Communications strategy on COVID-19 based on experience and lessons-learned</p>	<p>DLR # 9.2 By no later than September 30, 2021, MOH has updated the communication strategy for information on COVID-19 vaccines, their rollout, eligibility, grievance redress as well as adverse event information.</p>	<p>0</p>	<p>COVID-19 vaccine-related update to the MOH communication strategy is available</p>	<p>Value: US\$ 10 million.</p>
<p>(11) DLI # 11 Assess and plan actions to address gaps in supply chain and logistics for maintaining the cold chain for storage and distribution of COVID-19 vaccines</p>	<p>DLR 11.1 By no later than July 31, 2021, the Borrower has developed an action plan to address identified gaps in supply chain and logistics for maintaining the cold chain from points of entry to points of service for vaccines.</p>	<p>0</p>	<p>Cold chain action plan is developed and under implementation.</p>	<p>Value: US\$ 10 million</p>
	<p>DLR 11.2 The Borrower has deployed remote temperature monitoring devices in vaccine storage locations (not including Jakarta) and specifically:</p> <ul style="list-style-type: none"> a) remote temperature monitoring is installed and functioning at the Province and district level; b) remote temperature monitoring is installed and functioning at the Puskesmas level; c) end to end supply chain management and logistics information system is functional (at least for COVID-19 vaccines) and regularly in use in 2000 Puskesmas up to March 31, 2022. 	<p>0</p>	<ul style="list-style-type: none"> a) Remote temperature monitoring is installed and functioning at (i) the provincial and district level for all identified districts; b) Remote temperature monitoring is installed and functioning at the Puskesmas level in all identified districts. 	<p>DLR #11.2 Value: US\$ 45 million.</p> <p>DLR #11.2 (a) US\$ 15 million. Unit Price: \$150,000 for each percentage point of Identified Districts where remote temperature monitoring is installed and functioning at the Province and district level;</p> <p>DLR #11.2(b): US\$ 15 million. Unit Price: \$150,000 for each percentage point of Identified Districts where remote temperature monitoring is installed and functioning at the Puskesmas up to the Target. Target: all Identified Districts</p> <p>DLR #11.2(c): US\$ 15 million. Unit Price: \$7,500 per puskesmas where end-to-end supply chain</p>

			c) End-to-end supply chain management and logistics information system is functional (at least for COVID-19 vaccines) and regularly in use in up to 2,000 Puskesmas locations as of 31st March 2022.	management and logistics information system is functional (at least for COVID-19 vaccines) and regularly in use, as of March 31, 2022.
(12) DLI #12 Human Resource Capacity Building and Managing unintended impact of COVID response on essential non-COVID health services	DLR 12.1 By no later than July 31, 2021, the Borrower has developed a deployment/mobilization plan for ongoing COVID-19 response and mass vaccination in a manner that preserves a share of staffing to maintain Essential Non-COVID Health and Nutrition Services.	0	HR Mobilization plan that preserves essential services, is developed and implemented	Value: US\$ 10 million.
	DLR 12.2 The Borrower has confirmed that appropriate capacity building/ training of human resources for COVID-19 vaccine delivery has been carried out.	No	MOH has received confirmation of training completion for all districts implementing COVID-19 vaccination.	Value: US\$ 20 million; Scalable. Unit Price: \$40,000 per district that has confirmed that appropriate capacity building/training of human resources for COVID-19 vaccine delivery has been carried out up to the Target. Target: 500 districts

	<p>DLR 12.3 Essential Non-COVID Health and Nutrition Services are utilized at more than 90% of pre-COVID utilization, except for the tuberculosis program, which is utilized at 82% or higher of pre-COVID utilization</p>	<p>0</p> <p>(2019 performance) Programs & Indicators** Maternal - K4 visits 88.5% (KOMDAT/Program reporting) - Facility based delivery 88.6% (KOMDAT, Program) Nutrition Under 5s monthly weighing 73.6% (Program reporting) TB Case notification 67% (Program reporting) Immunization Pentavalent (3rd dose) 96.5 (Program reporting)</p>	<p>Targets for each program will be based on individual program performance in 2019.</p> <p>Programs & Indicators Maternal - K4 complete visits - Facility based delivery Nutrition Monthly Growth Monitoring of Children Under 5 TB Case Notification Immunization Pentavalent (3rd dose)</p>	<p>Value: US\$ 69 million Scalable; Unit Price: \$3,000,000 per calendar quarter for each program achieving the Target in each quarter between April 2021 and June 2022. Target: program is utilized at more than 90% of pre-COVID utilization, except for the tuberculosis program, which is utilized at 82% or higher of pre-COVID utilization: (a) in 3 quarters between April 2021 and June 2022 in the case of the nutrition program; and (b) in each quarter between April 2021 and June 2022 for all other programs</p>
<p>(13) DLI #13 Vaccine prioritization and distribution is based on pre-determined, fair and objective criteria.</p>	<p>DLR 13.1. The Borrower has developed fair and equitable criteria for prioritization and distribution of COVID-19 vaccines across its geographical areas through a consultative and transparent process.</p> <p>DLR 13.2 As of September 30, 2021, the prioritization, deployment and distribution of COVID-19 vaccines has conformed to the fair and</p>	<p>0</p>	<p>Vaccine prioritization and distribution criteria are developed, made publicly available, and COVID-19 vaccines deployment and distribution has</p>	<p>Value: US\$ 25 million</p> <p>DLR 13.1 Criteria developed and made publicly available: US\$5 million (prior result)</p> <p>DLR 13.2 As of September 30, 2021, the COVID-19 vaccines distribution has conformed to the above criteria: US\$10 million DLR 13.3 As of December 31, 2021, the COVID-19 vaccines</p>

	<p>equitable criteria referred to in DLR #13.1.</p> <p>DLR 13.3 As of December 31, 2021, the prioritization, deployment and distribution of COVID-19 vaccines has conformed to the fair and equitable criteria referred to in DLR #13.1</p>		conformed to the criteria	distribution has conformed to the above criteria: US\$ 10 million
<p>(14) DLI #14 A pharmacovigilance system is in place to report adverse events in a timely manner</p>	<p>DLR #14.1 The Borrower has developed and implemented a pharmacovigilance system to monitor any adverse events related to the COVID-19 vaccine(s).</p> <p>DLR #14.2 As of September 30, 2021, the pharmacovigilance system has been implemented and is functioning in accordance with the ITAGI Guidance, to monitor any adverse events related to the Program COVID-19 vaccine.</p> <p>DLR# 14.3 As of March 31, 2022, the pharmacovigilance system has been implemented and is functioning in accordance with the ITAGI Guidance, to monitor any adverse events related to the COVID-19 vaccine.</p>	<p>0</p> <p>0</p>	<p>The pharmacovigilance system is developed and is providing regular reports.</p>	<p>Value: US\$ 10 million The system has the ability to track the exact batch of COVID-19 vaccine Pharmacovigilance system is developed</p> <p>Value: US\$ 15 million As of September 30, 2021, the system is functioning and able to track exact batch of COVID-19 vaccines given to beneficiaries</p> <p>Value: US\$ 15 million As of March, 31, 2022, the system is functioning and able to track exact batch of COVID-19 vaccines given to beneficiaries</p>

ANNEX 2: Intermediate and PDO indicators, by Results Area (new AF indicators in blue)

Results Areas	Intermediate Indicators	PDO Indicators
<p>Improve hospital and health system readiness for COVID response and vaccination, and maintain essential non-COVID health services</p>	<ul style="list-style-type: none"> • Concrete measures to support and compensate health professionals for added COVID-19-related workload and risk are implemented • Number of beds temporarily converted for patient isolation and/or low-intensity medical care • Number of COVID-19 cases successfully treated, disaggregated by sex • Infection prevention and clinical management protocols developed and disseminated to all non-referral facilities • <i>Maintaining essential non-COVID services – Number of completed fourth ANC services delivered in the previous quarter as a proportion to the corresponding quarter in 2019</i> 	<ul style="list-style-type: none"> • Increased population immunity to COVID-19, as measured by number of persons who have received free vaccination with an eligible vaccine • Reduced service readiness gap in treating serious respiratory illness patients
<p>Strengthening public health laboratory, surveillance, and supply chain systems</p>	<ul style="list-style-type: none"> • Number of functional locations with remote temperature monitoring system. • Cumulative number of COVID-19 suspects tested by PCR or rapid molecular testing, disaggregated by sex • A surveillance mechanism for community-based reporting of outbreaks and new illnesses among humans and animals is functional • Cumulative number of cases reported in the pharmacovigilance system 	<ul style="list-style-type: none"> • Strengthened laboratory capacity • Improved reporting and surveillance system

Results Areas	Intermediate Indicators	PDO Indicators
<p>Enabling communication and coordination for emergency response and vaccine delivery</p>	<ul style="list-style-type: none"> • MOH supports the creation of a multisectoral coordination mechanism for COVID-19 response • MOH counters COVID-19 related misinformation and posts on its website • Cumulative number of cases MOH counters COVID-19 vaccine related misinformation and posts on its website • Cumulative number of website visitors to the COVID-19 communication portal set up by the Government of Indonesia 	<ul style="list-style-type: none"> • Enhanced community engagement and communication

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ANNEX 3: Implementation Progress of Environmental and Social Action Plans of the Parent's PforR

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
Management of Medical Wastes							
1.	Nominate responsible staff from the MOH and MOEF to jointly advise hospitals and laboratories in managing the increasing volume of medical waste during the pandemic, including through	Directorate of Environmental Health	Yes (Subset of DLI 4)	No	n.a.	31 May 2020	An appointment letter (SK) has been issued by MOH (Directorate of Environmental Health – no. HK.03.02/4/3429/2020 dated June 12, 2020), appointing a team in charge for oversight the management of medical wastes in healthcare facilities from MOH. MOH has also communicated such requirement to MOEF through an official letter requesting the assignment of responsible staff (Letter No. KL.03.01/4/2854/2020 dated May 15, 2020). However, an equivalent SK is yet to be issued by MOEF on the premise that such oversight and coaching functions are part of MOEF's regular duties and hence, a specific SK is not warranted. MOEF through regulation No. P.18/MENLHK-II/2015 outlines the mandate for each its Directorate Generals and Directorates.
	a. Conduct rapid assessment on current capacity/practice in the MOH's vertically managed hospitals, laboratories and field hospitals to manage medical waste and the expected volume of waste generated during the pandemic		Yes (subset of DLI 4)	No	n.a.	30 June 2020	Rapid assessments in a form of electronic survey to assess the current waste management practice and capacity has been commissioned across hospitals and laboratories, with an uptake of 525 respondents as of Oct 5, 2020. Majority of the response were from hospitals. Information on the proportion of respondents (e.g. referral hospitals, laboratories, etc.) has not yet provided. Ad-hoc meetings with sub-national health agencies (province and district) were also undertaken to assess waste management capacities, including issues and challenges. Such meetings were expected to complement the

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
							<p>survey findings. MOH will continue the survey to capture wider respondents and to coordinate with MOEF and sub-national health agencies.</p> <p><i>To be obtained: proportion of respondents by types of facility from current rapid assessment result (e.g. no of referral hospitals, other hospitals, laboratories, clinics, etc.)</i></p>
	<p>b. Advise hospitals and laboratories on the alternatives to manage their wastes (in house and external services), support approval of agreed options and develop the necessary work instructions for these alternatives. Based on agreed options for medical waste management jointly with the MoH, support procurement for goods/ equipment where needed, facilitate dialogue with third parties (waste transporters, cement kilns, landfills for ash disposal, and so on)</p>		No	Yes	n.a.	Ongoing	<p>Guideline on medical wastewater and solid waste management for healthcare facilities has been issued on April 14, 2020 by the Directorate of Environmental Health and posted in MOH website (here). Similar guideline but covering wider scope (including waste from all healthcare facilities and community self-isolation) has also been issued by MOH through decree No. HK.01.07/MENKES/537/2020. Both guidelines also provide alternative options for medical waste management in emergency and have been communicated to healthcare facilities in all provinces through virtual training whrganized jointly with MOEF, these training also served as platform for healthcare facilities in seeking advice on medical waste management (details in point c).</p> <p>MOH has also distributed four autoclaves to four referral hospitals in West Sumatera, Bali, Yogyakarta and Central Java; and four incinerators to Centre of Environmental Health and Disease Control Agency (BBTKL) in Banjarbaru, Jakarta, Surabaya and Yogyakarta to strengthen medical waste management capacity in these regions. The distribution of autoclaves and incinerators were based on recommendations</p>

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
							<p>from the Directorate of Healthcare Services and DG Disease Prevention and Control.</p> <p>During the mission, it was noted that MOH received a complaint letter from local NGO on medical waste management in RSUD Djafar Harun, North Kolaka, Southeast Sulawesi Province dated August 24, 2020. The complaint highlighting the suboptimal operations of wastewater treatment plan and incinerators since 2017 and the possibility of corruption in procurement of these items. MOH has coordinated with subnational health and environmental agency in North Kolaka Regency and Southeast Sulawesi Province to investigate the issue and provide guidance on the management of the waste, through letter no KL.03.01/III/901/2020.</p> <p><i>To be obtained: investigation result and action plan following complaint investigation.</i></p>
	c. Provide training to hospitals and laboratories on the alternatives to manage COVID-19 wastes (web-based training) and providing guidance for third parties on medical waste management.		No	Yes	n.a.	Ongoing	<p>MOH, collaborated with MOEF and WHO, held a total of 17 e-training (webinars) on medical waste management practices during COVID-19, covering audiences from sub-national health and environment agencies (province and district) and healthcare facilities (referral and non-referral hospitals, primary health care, laboratories) from all 34 provinces on June 22 – July 16. Topics covered include COVID-19 wastewater and solid management policies from MOH and MOEF, applicable regulations and guidelines, practical advice for implementation of these guidelines on site, as well as medical waste management guideline from WHO. A total of 15,360 audiences</p>

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
							attended the training. These training sessions were recorded and available online (here).
Occupational Health and Safety (OHS)							
2.	Training manuals and cascade training to hospital and laboratory workers for the proper handling of COVID-19 cases and specimens, including the proper usage of PPE (web-based training)	Directorate of Occupational Health of the MOH and National Institute of Health Research and Development of the MOH	No	Yes	n.a	Ongoing	<p>Relevant technical instructions have been issued and published (as of September 30, 2020). These include:</p> <ul style="list-style-type: none"> - Use of PPE for the handling of COVID-19 patients (here) - Protocol for Infection Prevention and Control (IPC) measures for healthcare settings (here). This is the fifth revision to accommodate new knowledge related to COVID-19 based on WHO recommendations. <p>The above guidelines are publicly available and have been disseminated to health workers.</p>
3.	Priority testing for healthcare workers and facility staff responsible for direct handling of COVID-19 at MOH vertical hospitals (i.e. cleaners, ambulance drivers, receptionists, etc.)	Directorate General of Health Service	Yes (subset of DLI 1)	Yes	n.a.	30 June 2020	A guideline which prescribes priority testing for healthcare workers and facility staff has been developed through Kepmenkes No. HK.01.07/MENKES/1591/2020.
Public Health and Safety							
4.	Additional capacity for patient isolation and low-intensity medical care by converting non-medical establishments with the needed equipment and human resources	DG of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services)	Yes (DLI 3)	No	n.a.	Ongoing	COVID-19 Task Force, under leadership from the National Disaster Management Authority (BNPB), has established a COVID-19 emergency hospital (RSDC) by converting an athlete dorm at Wisma Kemayoran for low-intensity medical care. There are a total 2,391 rooms with 6,011 beds (as of July 28, 2020).

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
							<i>To be obtained: MOH administrative records</i>
5.	<p>A system for assessing needs and monitoring distribution of PPE to health facilities based on needs across Indonesia*</p> <p><i>This action plan also addresses equity issues in PPE distribution.</i></p>	<p>The Center for Health Crisis of MOH for PPE;</p> <p>Directorate of Surveillance and Health Quarantine for Testing Kits;</p> <p>DG of Pharmaceutical Services for medical supplies</p>	Yes (subset of DLI 5)	No	n.a.	30 June 2020	<p>As of September 30, 2020, 4,963,900 coveralls have been purchased, of which 4,448,304 have been distributed across the country. 4,795,892 of N95 masks have been purchased, of which 2,895,580 have been distributed (here).</p> <p>MOH has used a forecasting tool developed by WHO, namely Essential Supplies Forecasting Tool (ESFT) to assess needs across provinces based on pandemic spread and growth. A logistic dashboard is also up and running to track distribution and supplies. These systems are being managed by the Public Health Emergency Operation Centre (PHEOC) of MOH.</p>
Medical Consent and Civil Rights to Privacy							
6.	<p>Measures to enhance the existing public Feedback and Grievance Mechanism (FGRM) for COVID-19 response, such as https://covid19.kemkes.go.id/ and hotline 119 ext. 9, and ‘Halo Kemkes’ in terms of their accessibility, credibility and level of response</p>	<p>Directorate of Referral Services Bureau Communication Public Service, Secretary General</p>	No	Yes	n.a.	Ongoing	<p>Currently there are 10 personnel in charge for the MOH-operated FGRM systems (in three shifts), including SMS and WhatsApp’s. The channels are accessible 24/7 and have been publicly disseminated through various media. Earlier FGRM management benefitted from additional personnel from the Military and the Indonesia National Police. Additional personnel, especially in preparation of COVID-19 vaccination is currently being assessed.</p> <p><i>Documents to be obtained: updated grievance records on COVID-19 management tracked with resolution status.</i></p>
7.	<p>A protocol for surveillance incorporating data protection measures</p>	<p>Directorate for Surveillance</p>	Yes (subset of	No	n.a.	Ongoing	<p>MOH’s Centre of Data and Information (Pusdatin) is leading the development of an electronic platform integrating Tracking COVID-</p>

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
	and consent is developed and disseminated to health facilities	and Health Quarantine; Center of Health Data and Information (Pusdatin)	DLI 6 and 10)				19 application with Allrecords TC 19, with the former serving as a dashboard to MOH management and the latter serving as a data entry platform. A protocol for data protection measures has been drafted, including a measure to encrypt individual data points. The tracking application, including data storage and protection, is oversights by the State Cyber and Code Agency (BSSN). <i>To be obtained: completion and issuance of protocols and evidence of dissemination incorporating, as a minimum, the principles set forth in the Personal Data Management Protocol</i>
Social Stigma							
8.	A communication strategy on public health messaging and community outreach on COVID-19 related facts, in coordination with media and civil society organizations and in line with good practice guidelines such as https://www.who.int/docs/default-source/coronaviruse/covid-19-stigma-guide.pdf	Directorate of Health Promotion Media: Bureau Communication and Public Service	Yes (sub-set of DLI 9)	Yes	n.a.	31 May 2020	A public health communication strategy has been prepared and launched by MOH. The Directorate of Health Promotion is in charge of the overall implementation of the strategy, together with the Bureau of Communication of MOH. Cascaded training has been implemented, targeting five provinces (i.e. Jakarta, South Sumatera, South Kalimantan, Central Java and East Java) and select districts in these provinces, including primary healthcare facilities. Off-the-shelve media, such as flyers, pocketbooks, short-videos, have also been prepared and can be used by sub-national governments, including primary care facilities in their efforts to implement COVID-19 public health campaign. As of to date, there are no reported plans for the expansion of the cascaded training/coaching and in the future, such training/coaching will be made at the request of sub-national governments and/or health facilities.

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
							<p>Public risk communication has regularly used public media, including websites, social media, radios to make information related to COVID-19 and its risks publicly available. Relevant contents have been endorsed by technical units and dissemination has been made in coordination with other sectoral agencies, including the Ministry of Communication and Information (KOMINFO).</p> <p>For both on-going initiatives, evaluation of their efficacy and coverage is yet to be conducted. With planned COVID-19 vaccination, current public communication efforts will likely need to be overhauled.</p> <p><i>To be obtained: an assessment of MOH's public communication strategy implementation</i></p>
Patients' security and safety							
9.	Strengthen the existing system to monitor patients' security and safety during isolation & treatment at COVID19 referral hospitals, including on aspects related to Sexual, Exploitation & Abuse/Violence against Children (SEA/VAC)	Directorate General of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services)	No	Yes	Monthly	Ongoing	<p>As part of hospital accreditation, each health facility is required to establish a Patient Safety Committee (<i>Komite Keselamatan Pasien</i>) that will coordinate with the National Patient Safety Committee (<i>Komite Nasional Keselamatan Pasien</i>) under the oversight of the Directorate of Quality and Health Facility Accreditation. Reporting to the national committee is voluntary in nature. Complaints and/or cases are categorized along generic classifications of incidents in line with the Ministerial Regulation of MOH no. 11/2017 and hence, it is difficult to generate specific incident classifications, including SEA/VAC. The above system is expected to be complemented by the FGRM system operated by MOH to enable public access to file cases related to patients' security and</p>

No.	Action	Responsibility	DLI	Re-current	Freq	Due Date	Status
							<p>safety, which is expected to be enhanced going forward.</p> <p><i>To be obtained: cases reported to the national committee and whether there is a spike in the time of COVID-19.</i></p> <p><i>Evidence of an operating system to monitor and track risks related to patients' wellbeing, including their security and safety during isolation and treatments at COVID-19 referral hospitals</i></p>

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ANNEX 4: Core Principles and Planning Elements of PforR

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
Core principle 1: Program E&S management systems are designed to (a) promote E&S sustainability in the Program design; (b) avoid, minimize, or mitigate adverse impacts; and (c) promote informed decision-making relating to a Program's E&S effects.				
1	The PforR system operate within an adequate legal and regulatory framework to guide E&S impact assessments, mitigation, management and monitoring at the PforR Program level.	Relevant	<p>Relevant laws and regulations pertaining E&S impact assessments, management of medical waste, occupational health and safety, community health and safety, individual rights to vaccination including consent, grievance management, access and inclusion are available in the country.</p> <p>A comprehensive assessment for relevant laws and regulations was conducted during the preparation of Primary Health Care Reform Program - I-SPHERE (P164277), Indonesia Emergency Response to COVID-19 Program (P173843) as well as the AF. The assessment confirmed no significant gaps with regards to policies, laws, and regulations. Vaccine prioritization is generally aligned with the WHO Strategic Advisory Group of Experts on Immunization (SAGE) and Indonesian Technical Advisory Group on Immunization (ITAGI).</p> <p>In terms of consent, while patient rights are protected by law, individual consent can be waived under emergency situations in the interest of public safety. On the basis of these laws, COVID-19 vaccination is mandatory in nature and penalties are</p>	A national COVID-19 vaccination program represents a massive undertaking with an unprecedented scale in the country. The scale and speed that it requires to reach herd immunity will likely put a strain in the existing system for the national immunization program. At the same time with the rate of infection still surging, there is a considerable strain on the existing healthcare system to cope with the impacts of the pandemic and respond to increasing demand for hospitalization. Logistical distribution, with different temperature requirements for cold-chains, will be challenged by the lack of infrastructure particularly in rural areas, with limited vaccine availability and types of vaccines that urban populations may have access to. Further, considering regional disparity, areas with low ratios of healthcare workers per-population particularly in remote regions in Eastern Indonesia, may face significant constraints with regards to outreach, safety monitoring, and

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
			enforceable by law for those who refuse on the ground of personal preferences. This represents a gap in the governing framework for the GoI's vaccination program against the VIRAT/VRAF.	overall administration of COVID-19 vaccination.
2	<p>The PforR system incorporate recognized elements of good practice in E&S assessment and management including:</p> <ul style="list-style-type: none"> i. Early screening of potential impacts. ii. Consideration of strategic, technical, and site alternatives (including the “no action” alternative). iii. Explicit assessment of potential induced, cumulative, and transboundary impacts. iv. Identification of measures to mitigate adverse E&S risks and impacts that cannot be otherwise avoided or minimized. v. Clear articulation of institutional responsibilities and resources to support implementation of plans vi. Responsiveness and accountability through stakeholder consultation, timely dissemination of the PforR information, and responsive GRMs. 	Relevant	<p>GoI's COVID-19 vaccination is generally aligned with the VIRAT/VRAF as recommended for use by the World Bank, WHO, and UNICEF, with the exception of individual consent as indicated earlier. Relevant measures to promote OHS and nosocomial infections during vaccination has been included in the MOH's technical guideline on vaccination services.</p> <p>Guideline to manage medical wastes from vaccination activities is also available in the technical guidance, with alternative methods to manage the waste for healthcare facilities with limited access to licensed disposal facilities are provided.</p>	<p>The massive scale of the vaccination Program likely strains the existing capacity of the Program to apply proper E&S management consistently across regions. In regards to OHS, particular concerns are raised on access for healthcare workers to Personal Protective Equipment (PPE). A system to monitor the distribution has been established, and its implementation is critical to ensure adequate PPE supplies are available all personnel involved. MOH is assessing the overall logistical needs for vaccination, including procurement and distribution of PPEs.</p> <p>With the availability of alternatives to manage the medical, effective supervision and enforcement from relevant agencies is critical in ensuring the proper management of the wastes.</p>

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
Core principle 2: Program E&S management systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program activities that involve the significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR financing.				
1.	The PforR Program system identify, and screen for adverse effects on potentially important biodiversity and cultural resource areas and provide adequate measures to avoid, minimize, or mitigate adverse effects.	Not Relevant	Not Relevant	Not Relevant
2.	The PforR Program system support and promote the protection, conservation, maintenance, and rehabilitation of natural habitats.	Not Relevant	Not Relevant	Not Relevant
3.	The PforR Program system avoid significant conversion or degradation of critical natural habitats. If avoiding the significant conversion of natural habitats is not technically feasible, include measures to mitigate or offset the adverse impacts of the PforR Program activities and take into account potential adverse effects on physical cultural property and provide adequate measures to avoid, minimize, or mitigate such effects.	Not Relevant	Not Relevant	Not Relevant
Core principle 3: Program E&S management systems are designed to protect public and worker safety against the potential risks associated with (a) the construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials under the Program; and (c) reconstruction or rehabilitation.				
1.	The PforR Program system promote adequate community, individual, and worker health, safety, and security through the safe design, construction, operation, and maintenance of	Relevant	Occupational health and safety issues are covered in the accreditation system for hospital and <i>puskesmas</i> , as well as relevant regulations:	While the country has a regulatory framework and guidelines on OHS and IPC in place, the current strained capacity in the healthcare system is challenging its optimal

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	<p>Program activities; or, in carrying out activities that may be dependent on existing infrastructure, incorporate safety measures, inspections, or remedial works as appropriate.</p> <p>The PforR Program system promote measures to address child and forced labor.</p>		<p>Government Regulation (PP) No. 50/2012 on Health and Safety Management. MOEF Regulation No 56/2015 Appedix VIII provides guidelines on health worker protection, health and safety; MOH Regulation 66/2016 on Occupational Health and Safety at Hospital.</p> <p>Occupational health and safety measures during COVID-19 response and vaccinations has also been developed.</p>	<p>implementation. Particular concerns are raised related to the limited PPE availability and long working hours of the healthcare workers.</p> <p>Prioritizing healthcare workers to receive the vaccines and allocating maximum daily working hours, as prescribed in the COVID-19 vaccination technical guidance, are expected to protect these front liners from risk of COVID-19 exposure.</p>
2.	<p>The PforR Program system promote the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated under the PforR.</p>	Relevant	<p>Government Regulations No.101/2014 on Hazardous waste management casts the country’s main hazardous waste management framework, which built upon “cradle to grave” principle with a rigid manifest system to track the flow of waste from the generator to the disposal facility. The requirements prescribed in key regulations are harmonized with the GIIP, including the provisions on waste identification, reduction, segregation, storage, transport, disposal and occupational health and safety for waste handler – with all activities to managing medical (hazardous) waste, including to store, transport, treat or dispose, require valid permit/license from relevant agencies.</p> <p>MOEF Regulation No. 56/2015 on Hazardous Waste Management from healthcare facilities outlines the specific</p>	<p>Although the provisions in key regulations are in accordance to GIIP, uneven distribution of waste management facilities hindering the optimal implementation of relevant regulations in the country. Most of licensed waste management facilities and transporters are located in Java Islands, with some areas outside Java have limited access to licensed disposal facilities.</p> <p>Additional wastes generated from COVID-19 response and vaccination program may add more burden to the strained system. Alternative approaches to manage the waste should there is no licensed treatment facilities available are provided by MOH and MOEF. Continuous interagency cooperation in addressing concerns related to medical waste</p>

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
			<p>requirements on the management of hazardous medical wastes from all healthcare facilities, including from hospitals and primary healthcare facilities (<i>puskesmas</i>).</p> <p>MOEF circular letter No. SE.2/MENLHK/PSLB3/PLB.3/3/2020 on infectious (hazardous) and domestic waste management from COVID-19 response provides guidance and alternatives management of medical waste during the pandemic.</p>	management and its supervision remains critical in ensuring the proper implementation of relevant regulations and guidelines.
3.	The PforR Program system promote the use of integrated pest management practices to manage or reduce the adverse impacts of pests or disease vectors	Not Relevant	Not Relevant	Not Relevant
4.	The PforR Program system provide training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with the relevant international guidelines and conventions	Relevant	MOH Regulation no. 46/2015 on Hazardous Waste Management from healthcare facilities make it mandatory for all personnel involved in the management of medical wastes to be trained. This implies that personnel assigned to handle wastes from vaccination activities need to also be trained.	<p>MOH and MOEF held various webinar and training on the management of COVID-19 related medical waste over the course of the pandemic.</p> <p>Specific training on the management of medical wastes from vaccination activities is currently being conducted, with a further roll out covering more participants is expected. However, it is noted that the training materials for the first two session slightly differ with the guideline prescribed in</p>

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
				technical guidelines. Update on the guideline and training material is currently being proposed to synchronizing the information.
5.	The PforR Program system include adequate measures to avoid, minimize, or mitigate community, individual, and worker risks when the PforR Program activities are located in areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or affected by climate events.	Relevant	Law No 44/ 2009 on Hospital regulates that location of the hospital must comply with environmental health and safety and spatial planning consideration. Ministry of Health Regulation No. 24/2016 on Technical Requirements for Healthcare Buildings regulates that hospital buildings must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at river bank area (erosion potential) etc.	No significant gaps. However, since the national COVID-19 vaccination program is a massive undertaking both in terms of its scale and speed, implementation practices will likely vary, with weaker performance in lagging regions with under-developed health systems.
Core Principle 4: Program E&S systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement and assists affected people in improving, or at the minimum restoring, their livelihoods and living standards				
1.	The PforR Program system avoid or minimize land acquisition and related adverse impacts.	Not relevant	Not relevant	Not relevant
2.	The PforR Program system identify and address economic or social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to resources they use or occupy.	Not relevant	Not relevant	Not relevant
3.	The PforR Program system provide compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid before taking land or restricting access.	Not relevant	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
4.	The PforR Program system provide supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment).	Not relevant	Not relevant	Not relevant
5.	The PforR Program system restore or replace public infrastructure and community services that may be adversely affected by the Program; include measures in order for land acquisition and related activities to be planned and implemented with appropriate disclosure of information, consultation, and informed participation of those affected.	Not Relevant	Not Relevant	Not Relevant
Core principle 5: Program E&S systems give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and to the needs or concerns of vulnerable groups				
1.	The PforR Program system undertake meaningful consultations if the Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities are potentially affected (positively or negatively), to determine whether there is broad community support for the PforR Program activities.	Relevant	The national COVID-19 vaccination program does not disaggregate population targeting based on indigeneity status. Since consent may be waived, the provisions of consultations, including the exercise of individual rights to refuse vaccination for public safety reasons, are currently not available in the current system.	Due to the emergency nature of COVID-19 vaccination roll-out, community consultations, including exercise of consent, which may likely be waived for public safety reasons, will be difficult to be implemented. The AF seeks to enhance MOH's public communication, emphasizing persuasion as well as tailored messages to various different sub-population groups, including

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
				vulnerable and marginalized population.
2.	The PforR Program system ensure that Indigenous Peoples/Sub Saharan African Historically Underserved Traditional Local Communities can participate in devising opportunities to benefit from exploitation of customary resources and indigenous knowledge, the latter (indigenous knowledge) to include the consent of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities.	Not relevant	Not relevant	Not relevant
3.	The PforR Program system give attention to groups vulnerable to hardship or discrimination, including, as relevant, the poor, the disabled, women and children, the elderly, ethnic minorities or other marginalized groups; and if necessary, take special measures to promote equitable access to PforR Program benefits.	Relevant	GoI's COVID-19 vaccination is non-discriminatory in terms of allocation and targeting. The national allocation and prioritization is generally aligned with WHO SAGE. However, MOH's COVID-19 technical guideline does not further specify vulnerable sub-groups, particularly those considered as vulnerable, disadvantaged, underserved and/or impacted beyond health and socio-economic dimensions and how to identify these groups.	People in remote areas, including vulnerable groups such as Indigenous Peoples and marginalized groups such as people with disabilities, LGBTQI, religious minorities may face constraints in accessing COVID-19 vaccines despite their willingness to be vaccinated. The assessment acknowledges that access equity remains low, with disparities in geographical access, health worker distribution, and quality of services, particularly in Eastern Indonesia. People who are not part of any government's registries or whose domicile do not match their administrative records may be excluded. This population may

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
				include, but not limited to, circular or seasonal migrants, homeless people and street children, transgender population, and isolated populations. As the transmission is disproportionately high in urban areas, certain urban populations might also be inadvertently excluded from targeting and identification due to mismatch between their actual residential address and their administrative records. They include people living in informal settlements, newly arrived migrants who have not updated their administrative record, as well as seasonal and transient migrants (including migrant students).
Core principle 6: Program E&S systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes				
1	The PforR Program system consider conflict risks, including distributional equity and cultural sensitivities.	Not relevant	Not relevant	Not relevant

ANNEX 5: Preliminary Environmental and Social Screening

Indonesia COVID 19 Emergency Response Additional Financing (P175759, PE) PROGRAM FOR RESULTS

Environmental and Social Initial Screening

Introduction:

The proposed Additional Financing (AF) will finance the scale-up Program activities and new activities to achieve Program Development Objectives (PDO) and enhance the impact of the parent Indonesia Emergency Response to COVID-19 Program (P173843). As the changes are aligned with the original PDO, the PDO would remain unchanged—to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia. This AF will play a critical role in enabling affordable and equitable access to vaccines to the GOI, as well as for nonvaccine immunization costs (e.g. personnel, transport, cold chain, surveillance, and quality assurance).

Program Boundary:

The Program for Results (PforR) is part of the World Bank's support which in the short-term focuses on strengthening the Government of Indonesia's (GOI) respond to the recent COVID-19 pandemic through increasing treatment and laboratory capacity, reporting and surveillance, and with this AF, immunity to COVID-19. In the medium-term, the Program also aims to reduce COVID-19 risk infection so as to reduce morbidity and mortality among program beneficiaries, while strengthening human capital and national system for public health preparedness for future resilience.

The program boundary has increased to accommodate the purchase of eligible vaccines and other related commodities such as syringes, alcohol, immunization cards, personal protective equipment (PPE), institutional strengthening measures such as frameworks for the safe and effective deployment of COVID-19 vaccines, and system strengthening and service delivery efforts to ensure effective COVID vaccine deployment. The program boundaries will also be extended to not only covering COVID-19 referral hospitals and laboratories, but also primary care healthcare facilities (*puskesmas*) as most of immunization services are held in this type of facility. The PforR closing date will be extended by one year to October 31, 2022.

Purpose of initial screening:

Within the scope of the AF, an additional assessment will be undertaken to also include environmental and social risks pertaining to COVID-19 vaccination activities supported by the PforR. Relevant aspects to be covered include:

- Occupational Health and Safety (OHS) and community health and safety related to the overall administration of COVID-19 vaccination, including potential contacts and exposure with high risk population groups, perceptions of efficacy of vaccines leading to non-vigilant behaviors.
- Handling of COVID-19 vaccine wastes (i.e. syringes, vials, PPEs, etc.);

- Public safety, including a pharmacovigilance system and Feedback and Grievance Redress Mechanism (FGRM) in place to report adverse effects in a timely manner;
- Patients' rights and consent processes for vaccination, particularly amongst populations who are skeptical and/or refuse vaccination.

An addendum to the environmental and social system assessment (ESSA) will be carried out to assess the above risk variables, on the basis of which additional measures to manage any significant gaps will be identified and agreed between the World Bank and MOH. The addendum will build on the ESSA of the parent program Indonesia Emergency Response to COVID-19 Program (P173843) and the current ongoing program: Indonesia – Supporting Primary Health Care Reform Program (I-SPHERE, P164277).

Key results and findings of the initial screening:

Initial screening was carried out based on the proposed result areas and inclusion of potential activities within each area. Further assessment, including stakeholder consultations, will be conducted during the Program preparation.

- The activities planned under this P4R will not have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people. The AF may include financing for cold chain facilities, vehicles and other logistics infrastructure as well as capacity building for frontline delivery workers at the request of the GoI. No adverse impacts to natural habitats, physical cultural property, natural resources are not likely since expected physical investments will be small-scale in nature;
- Medical waste management and community health and safety issues related to the handling, transportation and disposal of hazardous and infectious medical wastes. This includes wastes resulting from vaccine delivery such as sharps, vials and the disposal of expired vaccines. Vaccination will likely take place in the existing hospitals and community health centers (*Puskesmas*), which may be constrained in terms of waste-handling capacities. There are available guidelines from Ministry of Health (MOH) and Ministry of Environment and Forestry (MOEF), however, the increasing volume of waste, limited treatment capacity and lack of supervision due to the strains resources during this pandemic may increase the potential environmental risks—especially in the regions outside Java, as most of Indonesia's hazardous waste treatment facilities are located in the island.
- OHS risks for medical workers and staff related to the overall administration of COVID-19 vaccination. The risk includes possible exposure to infectious diseases which require additional protective gear for medical health workers.
- Community health and safety issue related with vaccine safety which require end-to-end supply chain and logistics management systems for effective vaccine storage, handling, and stock management—including rigorous cold chain control
- The availability of supplies, vaccine distribution and administration capacities will likely influence targeting and prioritization, which may leave high-risk population groups with no access to vaccination underserved. Individuals from low socio-economic status may be left out, particularly if distribution and targeting is weakly monitored (i.e., illegal sales of vaccines). Going forward, targeting must consider reduction of COVID-19 deaths, easing the strain on the healthcare system and supporting essential functioning of the society, in accordance with the existing global guidelines (such as WHO and CDC), scientific evidence, and expert advice.
- Identification of individuals belonging to priority groups will require significant efforts to consolidate existing population databases, including SIAK (Population Registry) of Ministry of Home Affairs, DKTS (Unified Database) of the Ministry of Social Affairs, BPJS registry, etc. Population targeting may need to involve state apparatus at its lowest level (i.e., village) to update their population registries. Further, the development and use of the population registry for COVID-19 vaccination must consider the protection of individual privacy.

- There is a considerable gap between regions/provinces/districts in Indonesia with regard to their capacity to distribute vaccines, which reflect the strength of the healthcare system in general. As such, even with an updated and accurate registry of prioritized groups, vaccines may not reach individuals due to logistical issues (e.g., lack of cold storage and transportation) and the lack of trained healthcare workers to administer the vaccines at service delivery points.
- There may be hesitations among the general populations to be vaccinated due to concerns about the efficacy and safety of the vaccines. While individual informed consent is an imperative part of vaccination, public health risk measures including in times of emergency will likely supersede individual preferences. Going forward, GoI needs to assess this risk and to develop strategies to assure the general public and seek public and individual informed consent.
- In responding to the above concerns, a robust communication strategy to educate and encourage public discussion, solicit feedback, engage mass media, and convey correct information (including changes in plans and how decisions are made) will be critical to support public buy-in and confidence. This would require transparent decision-making processes and accessibility to information. An accessible public complaint and grievance mechanism should also be set up and be informed to the public. Further, since the efficacy of the vaccines and their side effects may not be fully understood at the time of their administration, ensuring a pharmacovigilance system and Feedback and Grievance Redress Mechanism (FGRM) will be critical for public health safety.

Institutional Capacity to manage environmental and social risks:

MOH will remain as the implementing agency for the Program, with the arrangements to be slightly adjusted to include MOH's Immunization sub-directorate. Overall coordination responsibility within MOH remains with the Secretary General's Bureau of Planning and Budgeting. The parent program's implementation program was rated satisfactory in the last Implementation Status Report (ISR) of August 23, 2020 and the Program demonstrate good progress during the mid-term review. The directorates responsible for managing environmental and social risks are expected to remain the same and any additional implementing agencies will be assessed as part of the ESSA addendum. The Program Implementation Unit has been coordinating effectively and the program management structure and coordination mechanism was established with a Ministerial decree as required, coordinated by the MOH's Bureau of Planning.

During the last MTR mission, the team noted there has been good progress with some areas for improvements in the implementation of environmental and social Program Action Plan (PAPs) on infection control, medical waste management, public risk communication for patient safety, and personal data protection. The directorates responsible for the implementation of the PAP have also been coordinating with other key stakeholders to implement the required actions, including with other directorates in MOH or with other ministry and agencies.

In addition to the COVID-19 Emergency Response PforR, MOH is also implementing a World Bank-funded PforR, namely the Indonesia – Supporting Primary Health Care Reform Program (I-SPHERE, P164277), which largely focuses strengthening a primary health care (*Puskesmas*) accreditation system and disease control and environmental health, both communicable and non-communicable diseases. It is expected that this on-going initiative will complement COVID-19 vaccination since *Puskesmas* will likely be the main service delivery points.

Table A: Preliminary Risk Matrix

PDO	Additional Result Indicators (AF)	Expenditures	E&S Effects	Risks
<p>To prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Indonesia.</p>	<p>Improving hospital and health system readiness, including the quality of care:</p> <ul style="list-style-type: none"> • <i>Puskesmas</i> and <i>Posyandu</i> services for essential maternal health and other services remain uninterrupted in at least 90% locations <p>Strengthening public health laboratory, surveillance, and supply chain systems:</p> <ul style="list-style-type: none"> • Assessment of gaps in cold chain capacity for storage and distribution of incremental vaccines is completed • Pharmacovigilance system in place • ICT-enabled remote temperature monitoring deployed in the vaccine cold chain <p>Enabling communication and coordination for emergency response</p> <ul style="list-style-type: none"> • Population targeting/prioritization plan 	<p>The overall GoI's program costs is estimated US\$ 1.9 billion, of which US\$250 million is financed by the parent program and US\$ 500 million will be financed by this additional financing</p>	<p>The overall environmental and social outcome is expected to be positive. The PforR is expected to strengthen health service system response, including: 1) improving hospital and health system readiness, including the quality of care; 2) Strengthen public health laboratory, surveillance and supply chain system; and 3) Enable communication and coordination for emergency response.</p> <p>In the longer-run, the PforR also seeks to strengthened human capital and nation systems for public health preparedness for future resilience</p>	<p>The environmental and social risk is deemed to be substantial. There is a likelihood the Program would lead to some E&S consequences, but the risks are predictable and can be managed through risk management measures. The current strain capacity in responding to the pandemic may contribute to the possibility of the program may not achieve its E&S operational objectives or sustain the desired E&S results.</p> <p>Risk areas of concerns under AF include a) Occupational Health and Safety (OHS) and community health and safety related to the overall administration of COVID-19 vaccination, including potential contacts and exposure with high risk population groups, perceptions of efficacy of vaccines leading to non-vigilant behaviors; b) Environmental pollution and community health and safety issue related to the handling, transportation and disposal of COVID-19 vaccine wastes (i.e. syringes, vials, PPEs, etc.); c) community health and safety issue related with vaccine safety which require end-to-end supply chain and logistics management systems for effective vaccine storage, handling, and stock management—including rigorous cold chain control; d) public safety, including a pharmacovigilance system and Feedback and Grievance Redress Mechanism (FGRM) in place to report adverse effects in a timely manner; d) patients' rights and consent processes for vaccination, particularly amongst populations who are skeptical and/or refuse vaccination.</p>

	<ul style="list-style-type: none"> • Halo Kemenkes citizen information services suitably updated 			<p>There are risks of social refusal for vaccinations and some sub-national governments are contemplating to introduce punishment or sanctions for people who refuse to be vaccinated. Vaccinations under PforR should primarily use a persuasive approach.</p> <p>These potential environmental and social risks may likely be exacerbated by lack of capacity to contain COVID-19 infection due to the country's strained healthcare and other supporting system during this pandemic.</p> <p>While it is acknowledged that under the pandemic situation the government will need to thread and balance carefully the human wellbeing objective (of reducing COVID 19-related deaths and morbidity) and the objective of economic recovery especially in making decisions about prioritized groups, there are concerns that the government may focus on economic recovery more than public health goal. There may be trade-off but there are also ways to reconcile the two objectives. Prioritizing healthcare workers, essential sectors, and vulnerable populations may help to reduce the number of deaths and severe illnesses, to ease the strain on health system, and at the same time contribute to economic recovery.</p> <p>Under the parent PforR, MOH has demonstrated good progress in the implementation of E&S PAPs of the parent program, which will need to be maintained as part of the AF.</p> <p>A robust strategy for public communication and consultation including engagement with stakeholders and mass media should be developed</p>
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				<p>as early as possible. Regular and routine dissemination sessions to public and community should also be conducted to provide assurance, promote compliance, and encourage public oversight. Further, a clear division of responsibilities and accountability lines, between MoH and other relevant ministries as well as sub-national governments should be defined and agreed in order to improve coordination and to increase the effectiveness of the program.</p> <p>An ESSA addendum to further assess the existing GOI's systems, resources and capacity (both at the national and sub-national levels) to manage E&S risk under the AF will be conducted and appropriate mitigation measures agreed with MOH based on this addendum will be used to update Program Action Plans. The draft addendum is expected to be available by appraisal.</p>
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ANNEX 6: Minutes of Stakeholder Consultations

1. A Commissioner at National Commission on Elimination of Violence Against Women (24 November 2020)

- Only a handful of districts/cities have a considerably good databases of people with disability. In other districts, Dinas Sosial is tasked with the recording of people with disability but this register is rarely updated. The same observation about lack of accurate and updated data was also made about databases owned by disabled person organizations (DPOs). The lack of disability-aggregated data does not mean that people with disability are not registered in any government's database. Like other citizens, most people with disability have been registered in at least one government's database that is SIAK through their ownership of KTP and KK.
- People with disability are disproportionately affected by the pandemic through various pathways. First, some people with disabilities who are dependent on other people for their everyday life and those who live in assisted life facilities such as *panti*, may be more exposed to infection. As disability is closely related to poverty, the pandemic also brings negative economic impact on people with disability, for instance blind people who disproportionately represented in *masseuse* service.
- There are concerns around vaccination safety for people with disability whose disabilities are related to medical condition such as hormone irregularities, diabetic, and people diagnosed with cerebral palsy. Furthermore, not all people with disability have their disabilities medically diagnosed making it difficult to ascertain such potential risks.
- People, including children, with disability also still face barriers in accessing health care. The lack of disability-friendly facilities (such as ramps, guideblocks, sign interpreters) is one of the factors. Furthermore, there is still a deep and prevalent perception within community that regards people with disability as sick people. This perception may prevent another obstacle for people with disabilities from accessing vaccination since as sick people they are perceived as not needing preventive measure such as vaccination.
- Providing the correct information early on is key to increase trust among people with disability regarding the safety and efficacy of the upcoming vaccines. Dissemination of information needs to be channelled across various mediums (e.g. TV, social media, podcasts, radio) and formats to ensure accessibility for all spectrum of disabilities (e.g. visual and written for deaf, audio for blinds, etc). Engagement with religious leaders and disability activists, including well-known disabled-people organizations such as PPDI, HWDI, Gerkatin, Pertuni will be an important strategy to provide assurance and credibility to government's messages.
- The same principle of employing as many channels of communication as possible is also applicable in regards to feedback and grievance. Directly, individuals should be able to reach the government and convey their complaints through various mediums and receive official response immediately. Existing institutions that traditionally play the role of 'watchdog', such as Ombudsman, Komnas HAM, Komnas Perempuan, also needs to be engaged by the government.

2. Provincial Office of Health, DKI Jakarta (26 November 2020)

- As per Presidential Regulation on Covid19 Vaccination and Minister of Health Regulation No. 12 of 2007 on Immunization, the central government plays a central role in vaccination program. Their roles cover procurement of vaccines and other consumable instruments as well as the cold-chain and cold storage.

- The provincial government will assist the central government in the rolling-out of covid19 vaccines. Their roles include the mobilization of healthcare personnel, preparation of the venue/location preparation, transportation, warehousing and security.
- Currently, the provincial government is documenting their existing human resource (trained healthcare worker and administrators), the available coldstorage (public and private), as well as preparing the communication and education strategy for wider public. The provincial government has also trained 130 vaccinators for all Puskesmas in Jakarta and they will continue training for vaccinators at private health service as well as the administrators.
- Since October provincial government of Jakarta has started their own database updating to develop a roster of eligible individuals for vaccination through *dasa wisma* (which includes data on individuals under PBI, of productive age, and individuals with comorbidities). However, recently, the central government informed that the register will be given top-down from the national level. The list will be developed by compiling several national databases such as P-CARE (managed by BPJS that lists all JKN members, including PBI-APBD), SISDMK, SIAK, and other institutional registries as well as data from cellular operators.
- The top-down identification and targeting of eligible individuals raised concerns around inclusion and exclusion errors as there are risks that national-level databases do not reflect on the ground situation. It is still unclear what will be the mechanism in place when there's a discrepancy between the two registers (central versus local government). There is also no information if there will be contingency in forms of vaccines buffer for local governments to cover for eligible individuals who are not on the list. Not only this will be important for people who are not on the grand roster (from national government) but also for eligible people who might be registered in district/city or province other than where they are currently residing.
- Another point for clarification is the nature of vaccination programs. Will the vaccines be compulsory? If yes, to whom? The provincial government has just issued a new provincial regulation that stipulates monetary sanction for residents who refuse to be part of government's pandemic response including 3Ts and vaccination. However, the details of this sanction (e.g. who are obligated to take the vaccines and who are only recommended to be inoculated) are still being discussed and will be published through a governor regulation.
- In relation to the previous point, there are plans to make commercial vaccines available in the market. While this is a good measure to ensure wider access to vaccines without burdening the national budget, this plan comes with certain risks. First, the availability of commercial vaccines means that vaccination for wider public is not compulsory. Second, the government needs to regulate the market to ensure the availability and affordability of the vaccines, for instance by determining and monitoring the ceiling price as well as by stringent criteria for licensing. Finally, the public communication strategy needs to include public assurance about the efficacy and safety of the subsidized vaccines distributed through the government's program. For instance, the provincial government of Jakarta plans to not use the word 'free' as it connotes with low quality and left-over vaccines.
- In regards to public communication, the provincial government appreciates the efforts of the National Task Force through Kominfo in relaying information on covid19 vaccination early on. The provincial government is now preparing their KIE (communication, information, and education) materials to be rolled out at least 1 month before the actual vaccination. The main message is to communicate the known risks and to convince the public that the vaccines are safe and effective. There are also needs to develop specific campaign to bust certain/dominant rumors and misinformation regarding Covid19 and its vaccines. It is, however, acknowledged that providing the correct first and early information is much more effective than correcting misinformation circulating in the community.

- The provincial government will collaborate with various stakeholder such as Kominfo (they have special budget allocation for TV ads and blast) as well as digital and conventional mediums such as Jakarta Smart City platforms. The campaign will provide information on the price of each vaccine and will simulate the process of vaccines handling to help assuage any suspicion and mistrust. Engagement with ITAGI and other professional association will also be sought to provide public with experts reassurance. One of the informants mentioned that during the most recent nation-wide immunization program (MR vaccination), there wasn't a significant refusal among population in Java island while outside Java the uptake of the vaccines was lower due to the rumor of the MR vaccines being haram.
- In regards to FGRM, the provincial government will mobilize their existing channels such as JAKI, CRM, and direct complaints (through hotlines). These FGRM platforms have been linked to all SKPDs and the SKPD's performance to handle complaints and settle grievance are part of performance indicator both for the institutions and the leaders. It is, however, unclear whether these local platform are or will be linked with national FGRM mechanisms, and if so, how the communication and accountability pathways will look like.
- As any covid19 vaccines will be distributed through EUA, it is important to detect any adverse event following immunization (AEFI) and to determine the cause and whether or not such adverse events are correlated with or caused by the vaccines. Indonesia has already a mechanism in place to handle AEFI through experts commission on immunization at national level.

3. Multi-stakeholder forum: the Center of Epidemiological and Surveillance Research, University of Indonesia and Center for Indonesia's Strategic Development Initiatives/CISDI (10 May 2021)

- The national COVID-19 vaccination road map should aim for decreasing COVID-19 morbidity and mortality, and be based on the transmission risk. Priorities should be given to the population groups that geographically and demographically show rapid or widespread transmission of COVID-19, instead of the populations with higher economic contribution. This proposed road map could give more effective protection with the vaccine limited stock. As a model, DKI Jakarta province is now targeting elderly, and low-income community in densely populated areas.
- In view of SDG3's credo: Leave no one behind, Indonesia's vaccination strategy must articulate the commitment and the strategy to reach vulnerable and marginalised groups, and perhaps even redefining the groups, considering the current/unprecedented pandemic context, such as job seekers/unemployed youth, as well as those who are vulnerable to gender-based and domestic violence.
- A specific vaccination plan that accommodates the vulnerable groups is to be developed by the Government of Indonesia (GOI). Central and local governments need to review the practicality of the community registration or vaccination procedure, ensuring that those without the National Identification Number (NIK) are also eligible for COVID-19 vaccination.
- Double vaccination is the concern that pushes the need for NIK as the requirement for vaccine eligibility. However, it is highly improbable that a person volunteers for double vaccination. Apart from the NIK, COVID-19 vaccination could use the confident population and civil registration data (Dukcapil), or requires those without ID to provide information/evidence of name, age, and home address.

- Based on a quick CISDI's informal interview, Puskesmas in Jawa Barat Province uses bottom-up data collected by cadres to identify COVID-19 vaccination targets, due to perceived data gaps/inconsistencies available in the top-down/existing system (including the MOH's family-based health program, PIS-PK) in Puskesmas. CISDI will share with the World Bank the report of CISDI's Puskesmas Readiness Survey, an online rapid survey that focuses on the supply side of COVID-19 vaccination.
- The COVID-19 vaccination process provides an opportunity for civil registration and data collection for adult immunisation target. The GOI should explore the interoperability of this proposed data collection with the primary care data system, hence optimising primary health care's contribution to a robust data management system.
- Vaccination activity should also be a communication channel where the members of the community get further education or are reminded about the actions to take to prevent COVID-19 transmission. Public messages should be more consistent, particularly across government institutions.
- For wider and higher coverage, vaccination is to be made available in public venues, in addition to health facilities. The community could host a vaccination activity and support outreach activity to ensure that the elderly, people with disabilities, and other disadvantaged groups, are vaccinated.

4. Multi-stakeholder forum – waste management discussion: Nexus3 Foundation, Greeneration / Waste4Change, Yaksa Pelestari Bumi Berkelanjutan (YPBB) Bandung (10 May 2021)

- The availability of medical waste processing facility in Indonesia remains the biggest challenge in the overall management of medical waste in the country. The possible rise in medical waste from vaccination activities raised an additional concern on the management of the waste, including the possibility of suboptimal incineration process that could create additional waste management issues.
- The number of medical waste processed in the treatment facilities can be minimized through proper segregation of hazardous and domestic waste at source in the healthcare facilities. Capacity building for healthcare workers should be considered to ensure the segregation is conducted effectively at facility-level. Specific on vaccination activities, the minimization efforts can also be done through the effective implementation of procedures to distribute and store the vaccines. The efforts can minimize the waste generated by preventing vaccines wastage due to improper logistics management.
- The waste management technology in Indonesia is currently heavily dominated with the use of incinerators, although the MOEF regulation no. 56/2015 allows the use of other technologies such as: autoclaves, microwaves, and irradiation among others. The use of incinerators poses additional concerns, especially the suboptimal operations that could lead to air pollution. There is a need for capacity building to the relevant agencies and incinerator operators on the ideal specification and operational condition of the incinerators used to manage medical waste so as to ensure the proper equipment are installed and operated properly.
- Through the circular letters and waste management guidelines during the pandemic (including for vaccination activities), MOEF and MOH also suggested the use of autoclaves to manage COVID-19 related waste. The use of this technology is relatively more environmental-friendly as it will not produce air and water emission from the process, as compared to incineration. However, there are several hurdles in promoting the use of other technology (like autoclaves) in the country. One of which is the need to further treat the output from autoclaves as hazardous waste. The current regulatory regime defines the output of autoclaves as hazardous waste so it has to be further treated

through other hazardous treatment facilities. It is understood that the output from autoclaves should not be categorized as hazardous waste and should be treated as domestic waste. Redefining the output of autoclaves can help easing the burden to the current hazardous waste management system in the country and at the same time promoting the use of alternative technologies other than incinerators. Another possible hurdle that could also hinder the adoption of other alternative waste management technology such as autoclaves is the complicated and unclear permitting process from the MOEF.

- There is an opportunity to further improve the current regulations and/or guidelines on the management of used syringes (sharps) from vaccination activities by using needle crushers. Currently, the regulations and guidelines prescribed the use of safety box to temporarily store the used sharps before sending the wastes for further treatment. The use of safety box aims to prevent sharp injuries and nosomical infection to the workers during vaccination, as well as waste collection/transport/treatment activities. Needle crushers can be used to replace the safety box and act as an onsite treatment during vaccination to further minimize the risk of sharp injuries during the vaccination and/or waste management activities
- During the pandemic, there are several cases of improper disposal of medical waste to the environment and/or domestic landfill. This highlights the importance of enforcement from relevant authorities on the implementation of hazardous waste regulations in the country. Although the enforcement authority mandated to MOEF, MOH should also consider other efforts apart from capacity building to ensure the proper implementation of these regulations. One of which can be through internal audits.
- Further, for the overall improvement of healthcare waste management system in the country, MOH should consider providing specific guidelines in the management of medical wastes. This can be in form of ministerial regulation. The regulation could provide more clarity to the healthcare facilities on the management of hazardous waste and supplement the current MOEF regulation with a more practical approach within the current regulatory regime. Similar approach was observed for withdrawal of mercury containing medical devices, in which MOH issued a specific regulation to guide healthcare facilities on this issue.

5. Multi-stakeholder forum morning session: (18 May 2021)

Participants:

- Indonesian Anthropology Association (Asosiasi Antropolog Indonesia)
- Alliance of Indigenous Peoples of the Archipelago (Aliansi Masyarakat Adat Nusantara/AMAN)
- Center for Indonesia's Strategic Development Initiatives/CISDI
- NGO Forum on AIDS Care (Forum LSM peduli AIDS)
- Alliance of Women with HIV/AIDS (Ikatan Perempuan Positif Indonesia)
- NGO Inti Muda Indonesia
- NGO Jaringan Gaya Warna Lentera Indonesia (GWL-INA)
- Alliance of People living with HIV (Jaringan Indonesia Positif)
- National Commission on Violence against Women (KOMNAS Perempuan)
- Nitisara Indonesia
- NGO Organisasi Perubahan Sosial Indonesia
- Perkumpulan Keluarga Berencana Indonesia (PKBI)
- Persaudaraan Korban NAPZA Indonesia
- Center on Child Protection and Wellbeing (Pusat Kajian dan Advokasi Perlindungan dan Kualitas Hidup Anak/PUSKAPA, University of Indonesia)

- Pusat Pengajian Islam Universitas Nasional
- Puskesmas Toapaya
- Red institute
- Rumah Cemara
- Parahyangan University
- NGO Yayasan FKBP
- NGO Yayasan Hidup Positif
- NGO Yayasan Intermedika Prana (YIM)
- NGO Yayasan Karisma
- NGO Yayasan Kasih Suwitno
- NGO Yayasan Kemitraan Indonesia Sehat (YKIS)
- NGO Yayasan Kusuma Buana
- NGO Yayasan Orang Tua Peduli
- NGO Yayasan Pelita Ilmu
- NGO Yayasan RESIK
- NGO Wahana Inklusif Indonesia

The following points are proposed to improve inclusivity, access, and equity of the COVID-19 vaccination program:

- solution to ensuring that health workers could simultaneously reach the targets for maintaining the essential health care and conducting COVID-19 response and vaccination, considering the potential overwhelming workload;
- provision of more vaccination points, additional to one or two health facilities at villages and subdistricts; and identify and cater for supporting needs for a certain population, such as transportation to and from the vaccination points for the vaccinated persons and their companies/caregivers, and free CD4 test for people living with HIV/AIDS (PLWHA);
- an integrated, intersectoral collaboration that minimizes conflicting policies and activities; consistent data and information across sectors as well as central, provincial and district governments;
- regular evaluation, and adjustment of communication strategies and activities, involving different scientific fields, including psychology;
- more strategic, intensive, and extensive communication and outreach activities, particularly in villages and the communities, to:
 - a. fight misinformation
 - b. improve trust in government, local authorities and health professionals
 - c. provide correct and positive information on safe and halal vaccine
 - d. convince the members of the community to get vaccinated
 - e. emphasize equality and inclusivity
- improved capacity of health workers, government officials, cadres and other communicators in communicating the correct information
- tailored communication and outreach activities to cater for the needs of and provide access for, among others:
 - a. ethnic communities with unique traditions/beliefs
 - b. people living in difficult to reach areas

- c. people with disabilities
- d. people without the Single Identity Number (NIK)
- e. people without permanent address/nomadic community
- f. LGBTQI individuals
- g. The elderly
- increased and more diverse communication channels, prior to vaccination, at the community level; increased mobilization of various communities and involvement of prominent community figures, including the communities of people with disabilities, people living with HIV/AIDS (PLWHA), and LGBTQ;
- plan to improve health workers' understanding of the importance of allocating time to communicate with the members of the community to address their concerns and misperceptions;
- clear, detailed, and local-/context-sensitive information on:
 - a. COVID-19 vaccine and vaccination
 - b. the pros and cons of getting vaccinated
 - c. COVID-19 vaccination/vaccination plan for pregnant women
 - d. reporting adverse impact following immunization (AEFI)
 - e. reporting harassment and misconducts
 - f. legal rights concerning AEFI
 - g. data privacy
- mechanism to prevent and to report harassment and misconduct, along with the mechanism for regular monitoring and reporting;
- clear information and procedure for people with co-morbid and other medical conditions to increase vaccine acceptance/uptake; plan to monitor the implementation of the procedure by vaccinators, administrative staff, data administrators and health facility managers;
- communication to encourage the submission of correct and transparent information for vaccination registration and administration, to prevent potential AEFI;
- clear and strict confidentiality/data privacy protocol, ensuring that medical status and data submitted during the vaccination procedure is treated with high discretion and does not instigate stigma, discrimination, repercussion, and other negative consequences; and plan to ensure that the protocol is adhered to, in order to avoid the submission of false information due to the lack of trust in the management of personal data;
- mapping of and prioritization of people living in disaster-prone areas, considering the inability to follow the health protocol, post-disaster;
- procedure/guidance/plan to improve the planning and management of vaccination activity in the vaccination venue, comprises procedures for:
 - a. preventing COVID-19 transmission;
 - b. people with compromised immune system;
 - c. scheduling, ensuring well-calculated time management/scheduling to avoid missed appointments and financial loss.

- enhanced pharmacovigilance and clear mechanism to ensure transparency, addressing the concern about the safety of the new vaccines;
- collaboration of ministries and government institutions, such as the Community and Village Empowerment Office, to find a solution to NIK and mechanism for those without NIK; and using the vaccination as the opportunity to register people without NIK.

6. Multi-stakeholder forum morning session: (18 May 2021)

Participants:

- NGO Kebaya Yogyakarta
- GWL INA
- Alliance of People living with HIV (Jaringan Indonesia Positif)
- NGO HIVOS
- NGO Yayasan Srikandi Sejati
- NGO Yayasan Kasih Suwitno

Participants noted several issues pertinent to the current vaccination program. These are summarized as follows:

- Barriers to access health service or vaccine
 - a. For many marginalized groups, the use of National Identity Card numbers as the only mean to record and access vaccine is a barrier.
 - b. Access to social assistance support was also limited for people that cannot obtain National Identity Card.
 - c. Legal and bureaucratic administrative barriers are existed to obtain an Identity Card, especially for indigenous communities and transgenders. For example, although ruling of Constitutional Court if Indonesia enables “believers of indigenous faith” are allowed, in practice there are discrimination and stigma for marginalized groups.
 - d. Access to reach public administrative record office are difficult in some part of Indonesia (transport & distance), and process to create a citizenship record might take time and cost if not simplified.
 - e. Stigma and discrimination of certain groups have even made them unable to access public health system/essential service. For example, allegedly refusal of people living with HIV in Wisma Atlet (Covid19 Emergency Hospital) with no special need of specialized HIV medical care.
 - f. For people who are accessing the Anti-Retroviral Treatment (ART) or Hormone Replacement Therapy (HRT), there are hiccups during pandemic in relation to irregular service and low supply of medicines.
- Insufficient public communication related to several issues below
 - a. Vaccine safety and if its halal or not
 - b. Possible vaccine side effects, especially those who are immunosuppressed or are taking ART or HRT
 - c. Vaccine implementation, especially around scheduling and eligibility. Many cases in the community for people who came to the vaccine hub and being rejected without good explanation for why they are ineligible. Vaccine eligibility must be communicated more to the public.

- d. Public communication is needed on the management of domestic waste that are related to health prevention such as mask and gloves.
- Participants inputs on the way forward are
 - a. emphasizing on the public communication that is catered to the marginalized groups,
 - b. support the political will of the government to substantiate the rights of the marginalized group for equal access to vaccine
 - c. ensure the essential health services that are needed by the marginalized groups are not overlook, ensuring the regular delivery of service as well as the logistical side.
- World Bank noted efforts (cautiousness, proper process) of the government to ensure the safety of the vaccine. For example, to stop one batch of AZ after reports of side effects. However, the public communication may need improvement.
- Also, the government has considered strategy to use this vaccine momentum to work together with public administration office to identify groups who are eligible for citizen ID.
- World Bank took notes of the inputs and will discuss it further with MoH. Furthermore, World Bank would like to receive more inputs by the public via emails before the negotiation process with MoH.