

Joint Appraisal Report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

| | |
|--|-------------|
| Country | Indonesia |
| Reporting period | 2015 |
| Fiscal period | 2015 |
| If the country reporting period deviates from the fiscal period, please provide a short explanation | |
| Comprehensive Multi Year Plan (cMYP) duration | 2015 – 2019 |
| National Health Strategic Plan (NHSP) duration | 2015 – 2019 |

1. SUMMARY OF RENEWAL REQUESTS

| Programme | Recommendation | Period | Target | Indicative amount paid by Country | Indicative amount paid by Gavi |
|-----------|----------------|--------|-----------|-----------------------------------|--------------------------------|
| NVS IPV | Renewal | 2017 | 1,604,745 | - | US\$ 4,005,000 |

| Indicate interest to introduce new vaccines or HSS with Gavi support* | Programme | Expected application year | Expected introduction year |
|---|-----------|---------------------------|----------------------------|
| | | | |
| | | | |

*Not applicable for countries in final year of Gavi support

2. COUNTRY CONTEXT (maximum 1 page)

This section does not need to be completed for joint appraisal update in interim years



Governance

The government of Indonesia recognizes immunisation as one of the most cost effective interventions contributing to the reduction of morbidity and mortality of children and thus achieving the MDG / SDGs. A functioning Immunisation Technical Advisory Group (ITAGI) is in place. The Inter-Agency Coordination Committee for Immunisation (ICC) merged with the Health Sector Coordination Committee (HSCC), under the Chair of the Secretary General of Ministry of Health (MoH). Indonesia also has a functioning National Regulatory Authority (NRA) in place.

Programme Management

The Indonesian health system is decentralised. In order to ensure effective management of the immunisation programme, the government has issued a decree which aims to regulate the implementation of the national policy on immunisation programme throughout the country from national level to sub national level.

Programme Delivery

BioFarma provides services in production of vaccines as well as procurement and distribution of vaccines. The Effective Vaccine Management (EVM) assessment 2015 concludes that BioFarma performance is strong, with solid and reliable support for vaccine cold chain logistics. Vaccine distribution under the responsibility of provinces and districts is weaker. Based on a recent Inventory of the Cold Chain, at district and health center levels, much of the cold chain equipment requires replacement (983 units not functional, 831 units working but need maintenance, and 4,355 units working well). A cold chain inventory and replacement plan is underway, along with procurement of cold-chain equipment.

Immunisation Financing

The share of government health expenditure in general remains at a low 6%. The government expenditures on vaccines in 2015 increased to US\$59,963,804 from US\$43,640,000 in 2010. While vaccine costs appear to be secured going forward, operational costs, catalytic funding for new vaccine introductions (including financing of specific studies preceding introduction) and service delivery costs (covered by subnational level) are less secure. Costs incurred at province and district levels is not well documented and therefore not fully captured.

Table 1. Expenditure Immunisation - Indonesia 2015

| Expenditure by Category | Expenditure Year 2015 | Source of Funding | | | |
|---|-----------------------|-------------------|-------------------|---------------|---------------|
| | | Country | GAVI | Unicef | WHO |
| Traditional Vaccines (BCG, DPT, OPV, Measles1st dose, TT, HepB) | 27,760,736 | 27,760,736 | | | |
| New and underused Vaccines | 17,943,023 | 10,031,781 | 7,911,243 | | |
| Injection Supplies (both AD Syringes and syringes other than Ads) | 5,391,344 | 4,886,845 | 504,499 | | |
| Cold Chain Equipment | 3,536,089 | 3,536,089 | | | |
| Personnel | 2,895,589 | 2,687,444 | 208,144 | | |
| Other routine recurrent cost | 1,926,022 | 1,926,022 | | | |
| Other Capital Costs | 11,577,577 | 9,134,887 | 2,402,248 | 25,775 | 14,666 |
| Campaigns costs | - | | | | |
| | - | | | | |
| Total Expenditures for Immunisation | 71,030,380 | 59,963,804 | 11,026,135 | 25,775 | 14,666 |

3. GRANT PERFORMANCE AND CHALLENGES(maximum 3-4 pages)

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5



3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

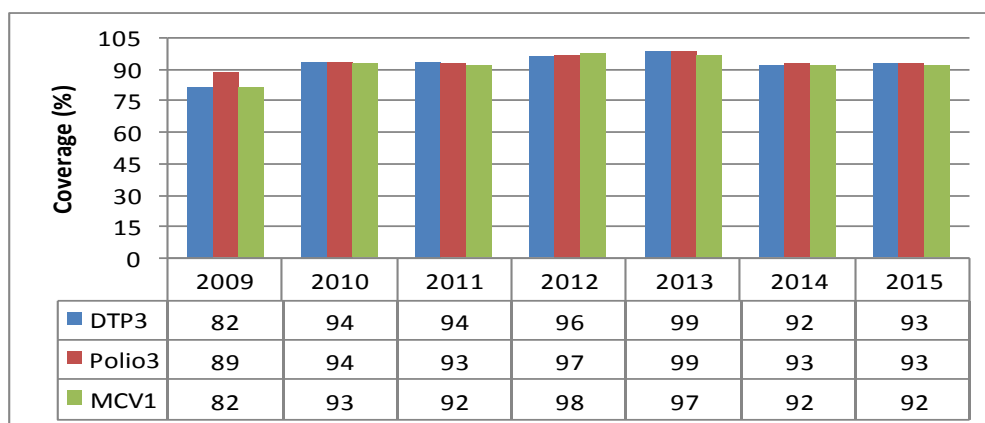
Coverage and Equity

Indonesia has successfully rolled out pentavalent vaccine and managed to sustain a fairly high coverage during the reporting period. However, coverage seems to stagnate and major equity challenges remain. Problems with data quality also remains high.

Since 2014, coverage of penta 1 has declined and penta 3 remains low (81% WUENIC data). Of concern is also coverage of MCV, which has also dropped (MCV1 from 77% to 69%, MCV 2 remains the same, WUENIC data). Discrepancies between official and administrative data shows that the country is aware of data quality problems and weaknesses in the reporting system (DTP3 Administrative reported coverage is 91% and Official reported coverage is 84%).

Based on administrative data in the WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases (JRF), the trend of routine immunisation coverage shows that the immunisation programme has reached a good performance in covering children as indicated in table 2.

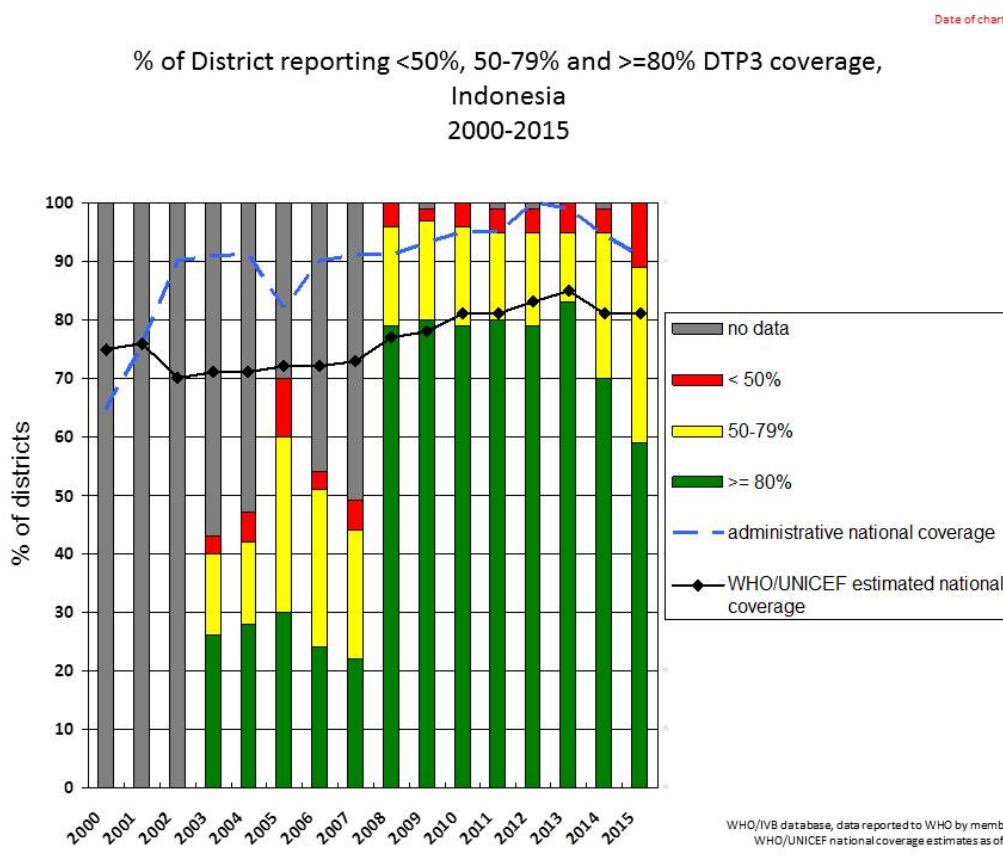
Table 2. Coverage of Immunisation in Indonesia 2009-2015



However, recent WUENIC estimates show DPT-Hb-Hib3 at 81% (2015) – which is stagnant from 2014. Data quality and discrepancy issues are highlighted by WHO and UNICEF, particularly in summary of the

estimation process for MCV1 and MCV2. MCV1 coverage is estimated at 69% (21% discrepancy from administrative reported data) and MCV2 coverage is estimated at 76% (46% discrepancy from administrative reported data). The recent change of MCV schedule from 6 years to 18-24 months impacts on coverage data. In the WUENIC report it is noted: *“Reported data excluded. No explanation provided for continued low levels of reported coverage for second dose of MCV following change in schedule. Reported target population appears to cover multiple birth cohorts.”* Looking across data reported from administrative, official estimates and WUENIC, all show measles and pentavalent coverage stagnating or dropping.

Official data from 2015 shows that 69% of districts reported DTP3 coverage $\geq 80\%$ and only 35% of districts reported MCV coverage $\geq 95\%$. The variance in MCV coverage between districts is high and is a major concern. WUENIC data estimates show less than 60% of districts reported DTP3 coverage $\geq 80\%$, and that 11% of districts reported coverage $< 50\%$.



The IDHS from 2007 and 2012 shows that there is little difference in immunisation coverage by sex, but the geographical variance between provinces is significant. Provinces such as Papua (35%) and West Sulawesi (58%) are far from their targets. Hard to reach areas include remote, sparsely populated eastern provinces and urban slums. Coverage also varies between wealth quintiles (Q5 85% versus Q1 45%), birth order (first child 76%, 6+ 36%) and mother’s education (highest 86% and lowest 26%).

Strategies to increase immunisation coverage and reduce inequities include Drop Out Follow Up (DOFU) in areas with low immunisation coverage targeting 0-11 months and 12-36 months old children in 60 districts in 18 provinces, Sustainable Outreach Services (SOS) activities conducted in 23 districts in 12 provinces. Other initiatives are also ongoing in specific low coverage districts implemented by partners, for example Rapid Pro in Djakarta slum areas supported by UNICEF, and the START Project in 2 provinces through WHO.

Co-financing

Indonesia self-procures pentavalent from the national manufacturer BioFarma. Until 2016, Indonesia has purchased 32,546,435 doses (by country funds) and 24,783,800 doses (by Gavi funds). The co-financing of NVS pentavalent is described in table 3. In 2015, stock analysis was conducted at all sites where stock

registers were available. Based on the EVM 2015, vaccine arrival was 100% in time and adequate storage capacity reached 81%. However, stock management and maintenance were areas of concern.

Table 3. Co-financing Pentavalent Vaccine 2013 – 2016

| Year | Required Co Financing GAVI (by DL) in doses | | Actual Purchased in doses | |
|---------------------|--|------------|------------------------------|------------|
| | GAVI | Country | GAVI | Country |
| 2013 | 3,688,100 | 917,100 | 7,081,205 | 1,963,045 |
| 2014 | 13,415,500 | 6,607,700 | 10,002,395 | 11,402,120 |
| 2015 | 7,770,200 | 11,655,300 | 7,700,200 | 9,764,170 |
| 2016 | 3,848,600 | 15,394,200 | - | 9,417,100 |
| 2017 | - | 19,529,400 | - | - |
| Total vaccine doses | 28,722,400 | 54,103,700 | 24,783,800 | 32,546,435 |

Adverse Events Following Immunisation (AEFI)

In 2015, Indonesia developed a vaccine safety website. The website is an instrument for Recording Reporting (RR) of AEFI seriously by the immunisation staff, etiology study and causality as AEFI Commission recommendation. Training on the vaccine safety website has been conducted in 12 provinces with 22 provinces expected in 2016. An online AEFI learning tool has also been developed in local languages with the support of WHO.

NVS Penta

In 2017, Indonesia will cover the full cost of pentavalent vaccine.

NVS IPV

In the last 12 months, the Acute Flaccid Paralysis (AFP) surveillance performance has been declining. The main reason is withdrawal of WHO support for surveillance officers in combination with low commitment by provincial governments.

The government of Indonesia has identified a preference for using a BioFarma 5 dose vial stand-alone IPV. BioFarma is currently working with Sanofi Pasteur to enter into a partnership where Sanofi would supply ready-to-use vials for 2016. From 2017, Sanofi will provide pre-formulated, inactivated IPV bulk that would be filled by BioFarma in a 5 doses presentation. The NRA of Indonesia has been notified of the proposed BioFarma/Sanofi partnership approach and has given guidance on the regulatory requirements that would be entailed with this arrangement.

3.1.2. NVS future plans and priorities

Indonesia has an ambitious plan for vaccine introductions over the coming year.

Firstly, Indonesia has committed to sustaining Polio free status, maintaining MNT elimination status, and enhancing coverages equitably to reach 90% national coverage and 80% in every district along with achieving measles elimination and rubella/CRS control by 2020.

Starting from July 2016, one dose of IPV is added gradually into routine basic EPI schedule at the time of with DPT-HB-Hib3 and bOPV-4.

For 2017, Indonesia will introduce the following new vaccines through the exceptional catalytic support window (Gavi supporting 50% of the doses):

- **Japanese Encephalitis (JE)**

The JE campaign will be given to target population aged 9 months to 14 years in all 9 districts of Bali Province, and will be followed by introduction of JE vaccine into routine programme. The target population is 897,050. This introduction is also supported by PATH.

- **Measles Rubella (MR) Introduction**

In 2017-2018, Indonesia plans to conduct a phased MR catch up campaign targeting 69,877,300 children 9 months to 15 years of age. The MR vaccine will be used to replace both doses of current vaccines at 9 and 24 months 1 month after MR catch up campaign. This is a very high commitment and needs strong coordination with the MoE, MoRA, medical professional association, and sustained technical assistance from partners.

- **HPV Demo Project**

The HPV demo project will be launched in 2 districts on Java Island. It is a school based programme, and first dose will be administered in August 2017.

In addition to the Gavi funded HPV demo project, the MoH is also introducing HPV vaccine in all districts of Jakarta province in 2016 fully funded by the national government.

Preparations are currently ongoing for the PCV introduction planned in 1 province (Lombok province, 2 districts) in 2017 financed by the government of Indonesia.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

The Gavi HSS support has suffered major delays, nevertheless some critical activities have been implemented especially in relation coverage and equity in targeted low coverage districts.

The reprogrammed HSS support amounting to US\$9.4 million focuses on 31 districts with low coverage and high childhood mortality. These districts contain almost 20% of the annual birth cohort of 4.6 million, and most of these are in densely populated urban poor areas.

The three objectives are:

- Improving DPT3 immunisation coverage in low coverage area;
- Capacity development on ensuring data collection and reporting;
- Improving the competency of immunisation staff by strengthening implementation of MCH-Immunisation materials for Midwifery institutions.

Both Gavi and government funds go towards supporting these activities down to health centre level. In recognition of the low coverage in some remote eastern areas, there are some proposed activities that focus on a smaller number of districts such as the Drop Out Follow Up (DOFU) implementation, Recording and Reporting (RR) implementation and the Sustainable Outreach Services (SOS) implementation in remote areas (25 districts). It was decided to focus these activities on selected districts with low coverage to ensure greater impact and real improvements rather than spreading the activities out more broadly.

3.2.2. Grant performance and challenges

Programmatic Achievements include:

- Increasing immunisation coverage especially DPT-HB3 / DPT-HB-Hib3 in 328 districts/cities with low immunisation coverage area through innovative activities (DOFU Immunisation, SOS strategy) Increasing UCI village over 81,8% (year 2015);
- DOFU Immunisation conducted in the 25 districts – 1,143 villages;
- SOS immunisation activities conducted in 12 provinces, 23 districts/cities, 109 health centers and 959 villages;
- Implementation of Data Quality Self-Assessment (DQSA) in 190 districts/cities;
- Baseline Coverage Survey at 10 provinces in 31 districts by independent organization (University of Indonesia 2015);
- 92,928 health workers and volunteers trained in social mobilisation and how to find drop outs (the target is to train 263,704 health workers);
- Increasing capacity of immunisation staff at 305 hospitals (government and private sector);
- Activities to increase demand for immunisation targeting Civil Society Organizations in the 31 districts including Midwives Indonesian Organization, Scout Movement, PKK, religious leaders and community leaders;
- Infrastructure for web-based RR in 64 districts and 632 health centres developed.
- Guidelines and module of teaching material of Immunisation and MCH for health education institutions developed;
- Immunisation forum created in order to overcome the negative attitudes towards vaccines and immunisation; and
- National EVM Assessment – with 17 provinces in 26 districts (70 sites) as sampling sites completed.

Programmatic Challenges

- Immunisation coverage discrepancies in pockets within provinces and districts, and risk for vaccine preventable diseases (VPD) outbreak. APF Surveillance performance is declining posing risk to Polio free status, (measles and VPD outbreaks still occur suggesting population immunity gaps despite high reported administrative coverage);
- Discrepancies between administrative data and coverage survey ;
- Many hard to reach areas which need to be covered through SOS activities;
- Drop out of immunisation due to low awareness of benefits of immunisation as well as insufficient systematic tracking and follow up in some areas;
- Limited number of and limited capacity among staff at national and provincial level to conduct the planned intensive monitoring, technical assistance and follow up action, based on results of coverage survey at 31 districts in 10 provinces. Additionally, there is a high staff turnover;
- Limited allocated operational budget for immunisation programme at local government in some areas;
- Lack of knowledge among health workers about immunisation programme and lack of confidence on multiple injection;
- Recent incidents of counterfeit vaccines might impact on public confidence for immunisation and coverage.

Implementation challenges

By the end of 2015, the country reported a remaining balance of about US\$8 million (out of original budget of US\$9.4 million). Reasons for slow implementation include:

- Delay in translating the allocated budget into activities according to the existing procedures;
- Competing priorities between government funded activities and donor funded activities;
- Weak coordination and limited monitoring.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

Given the slow implementation of activities and the urgency to address identified coverage and equity challenges in the country the Joint Appraisal mission highlighted the need to urgently accelerate implementation of HSS activities and put in place a better coordination and management structure. The MoH has proposed a slightly revised budget with a timeline until mid-2017. The activities remain the same with minor changes (two activities have merged and one activity has been allocated a higher budget). The activities have been divided into four programmatic areas:

- Immunisation coverage and equity
- Quality of services
- Demand promotion
- Data and information system

The MoH is also proposing a tighter monitoring of the activities. Reporting on progress will also be more frequent, with monthly reporting internally within MoH and quarterly reporting on progress to Gavi.

The Joint Appraisal and Transition mission also highlighted the need to ensure remaining HSS activities contribute to a sustainable immunisation system in the context of Indonesia transitioning out of Gavi support. The Secretariat may have to come back and revisit this issue depending on the progress in implementation of HSS activities.

3.3. Transition planning (if relevant)

A transition mission was carried out in July 2016 jointly with MoH and partners. Although a number of programmatic challenges were identified, in view of remaining balance of Gavi funds no specific transition plan was developed.

3.4. Financial management of all cash grants (e.g. HSS, VIG, campaign operational cost grant, transition grant)

Financial performance and challenges:

Actual versus planned financial expenditure:

Based on approved budget details for HSS, NVS and VIGs -operational costs (please find attached the financial statement):

- No major issues arising from Cash Programme Audit
- No modifications made to financial management arrangements
- Gavi funds are recorded in the state budget document (DIPA)
- Further disbursements of Gavi cash grants to provincial health offices use bank accounts in the name of MoH via electronic transfers to banks at provincial level
- The Independent audit of all Gavi supported programmes for the current financial year and any future financial years has been undertaken by Indonesian audit firm BPKP

Any key challenges: Regarding the financial management of VIGs or operational costs:

Indonesia has been a Gavi recipient since 2002 and to date Gavi has committed US\$147.4 million to the country's programme, of which US\$120.6 million include the last tranche of HSS (US\$9.4 million) which was disbursed in July 2015.

The below table represented the status and utilization of funds of Gavi grants including NVS:

| Grant Name | Income | Expenditure | Balance |
|----------------------------------|-----------------|-----------------|------------------------|
| HSS | US\$ 24,827,500 | US\$ 16,646,935 | US\$ 8,180,565 |
| VIG-PENTA | US\$ 3,791,000 | US\$ 1,834,320 | US\$ 1,956,680 |
| VIG-IPV | US\$ 3,688,500 | US\$ 1,211,039 | US\$ 2,477,461 |
| NVS-PENTA | US\$ 44,321,000 | US\$ 30,548,505 | US\$ 13,772,495 |
| NVS-IPV | | | - |
| CSO A & B | US\$ 4,000,500 | US\$ 4,000,500 | - |
| ISS | US\$ 40,100,000 | US\$ 40,100,000 | - |
| Sub Total | | | US\$ 26,387,201 |
| Interest and Other Income (fees) | | | US\$ 1,269,141 |
| Total | | | US\$ 27,656,342 |

The current HSS has a no cost extension to 30 June 2017. Gavi will determine if the remaining balances of other grants are to be incorporated under the new HSIS framework for use.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

| Prioritized strategic actions from previous joint appraisal/HLRP process | Current status |
|--|-------------------|
| 1. Conduct drop-out follow up (DOFU) and sweeping in 31 districts with low coverage/large number of unimmunized children based on baseline profile (after coverage surveys in each district) | Ongoing |
| 2. Reach the un-immunized children living in hard to reach areas using Sustainable Outreach Services (SOS) strategy | Ongoing |
| 3. Communication forum established for demand generation in partnership with LGAs, NGOs and others | Ongoing |
| 4. Recruitment of monitors (temporary contracts) to conduct intensive monitoring, technical assistance and follow up actions based on the results of the coverage survey at 31 districts. | Not yet initiated |
| 5. Cold-chain improvement (EVM assessment, inventory of cold chain and procurement of cold chain equipment). | Ongoing |

In addition the country has identified the following areas in need of technical assistance:

Technical support towards Vaccine Preventable Disease Surveillance:

- **Continue to provide high quality technical support to ministry of Health and partners, in developing, sustaining strong surveillance systems, policies, and human capacities at the national and province level**
 - Continue to focus on national case-based surveillance for polio (AFP), measles, rubella, diphtheria, and neonatal tetanus
 - Support staff development at the national and province level thru WHO organized trainings and workshops
 - Strengthen the policies related to the collection and use of surveillance data in Indonesia (current policies mandatory reporting of 26 communicable diseases already exists but the policy needs to be more explicit, more detailed, and more enforceable)
 - Strengthen the use of data to inform decisions at the local and national level through better data systems, advocacy with health leaders to use data to base decisions on, and funding of specific surveillance studies.

Polio End game activities are fully implemented and country remains polio free

- Switch of t OPV to B OPV
- Introduction of IPV in July and subsequently IPV reach high coverages
- High OPV 3 coverages uniformly, risk assessments
- Polio Outbreak preparedness strategies are in place a
- Support MOH in Environmental Surveillance in 1-3 major urban centers in Indonesia with the full support and leadership from the involved province, lab, and MoH.

Assist the MoH in developing and implementing a cohesive country-funded network of public health laboratories

- Ensure Polio laboratories are fully functional and support programme
- Measles Rubella lab network is expended WHO accreditation status to support MR elimination target

Increase coverages: Indonesia has around 1 million children who are un- or under-vaccinated. WHO will work closely with MOH and partners to achieve high uniform coverage in country, equitably, ensuring that there are no pockets of low coverage.

- Enhancing the quality of EPI data WHO plans to focus on technical support for district level immunisation coverage surveys. These household surveys are the current gold standard for measuring immunisation coverage among young children.

5. PRIORITISED COUNTRY NEEDS¹

| Prioritised needs and strategic actions | Associated timeline for completing the actions | Does this require technical assistance?*(yes/no) If yes, indicate type of assistance needed |
|--|--|---|
| Strengthening national capacity to formulate evidence-based policies for introduction of new and underutilized vaccines | | Yes, Cash Support for new vaccine introduction at province and districts level |
| Strengthening data collection and analysis | | Yes, TA from UNICEF and WHO |
| Strengthening Cold chain Management including private sector | | Yes, TA from UNICEF and WHO |
| Advocacy to decision maker and parliament related immunisation budget allocation including improving technical skill | | Yes, personal experts to advocate decision maker (Governor, Bupati) and Parliaments Capacity building on Advocacy skills from UNICEF |
| Strengthen Polio and measles Surveillance to monitor the disease trends and impact of vaccination programme | | TA required from WHO including support to Public health laboratories |
| In view of number of new vaccine introductions and large scale SIAs to be implemented in 2017 there needs to be continued TA to the MoH. | | Yes, TA from UNICEF and WHO |

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS



This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

| | |
|--|---|
| Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism | The Joint Appraisal was endorsed by the relevant national coordination mechanism: draft was circulated among all concerned for feedback/comment. Joint Appraisal was endorsed through HSCC Meeting that attended member of HSCC |
|--|---|

¹Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

| | |
|---|---|
| | (including inter – agency and CSO) in September 1, 2016 and reviewed by Gavi. |
| Issues raised during debrief of joint appraisal findings to national coordination mechanism | None |
| Any additional comments from: | |
| <ul style="list-style-type: none"> • Ministry of Health • Gavi Alliance partners • Gavi Senior Country Manager | |

7. ANNEXES



This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

Reports related to finance and the audit report by the Board of Supervisors Finance and Development (BPKP, the government auditor) were collated. The Joint Appraisal was done through a consultative process involving the HSCC members including international organizations, CSOs and relevant programmes, looking in depth at current issues and challenges of EPI/HSS programme. A draft Joint Appraisal was submitted to Gavi formally and circulated within the Secretariat for comments. The final draft was prepared in country in consultation with partners, and submitted during the HSCC meeting for approval.

Annex B: Changes to transition plan (if relevant)

Current Situation of Measles and Rubella

Based on Case Based Measles Surveillance (CBMS) data in 2008 – 2015 (as of 15 November 2015), there are a total 7417 rubella cases with >50% of the cases among 5-14 year and >25% of the rubella cases occurred in above 14 years. CBMS Data shows a high percentage of confirmed rubella cases above 15 years of age there is 23-27% nationally, in Yogyakarta with better surveillance is 39-40% and the percentage even higher among women (48%).

Sero epidemiology study of Rubella IgG antibodies among pregnant women from seven Asian countries (including Indonesia) was conducted in 2004 and the overall seronegative prevalence was 21.7% for pregnant women in Indonesia.

Results of sero-prevalence study among females 15 years and above from urban area of Indonesia in 2007 (Basic Health Research, NIHRD 2007) showed that from 8,802 specimens obtained from women aged 15 years and above, 86.6 % showed Ig G positive for Rubella, with the highest proportion (>80 %) found among females in reproductive age.

Objectives of the vaccine introduction

The goal of MR vaccine introduction is to contribute to the reduction of infant morbidity, mortality and disability due rubella infection in women during early pregnancy can severely affect the fetus, resulting in miscarriage, fetal death, or the combination of disabling conditions collectively called congenital rubella syndrome (CRS), which includes heart disease, blindness and deafness in Indonesia and will help to reach Sustain Development Goal.

The specific objectives of this plan are:

1. Immunize at least 95% of infants 9 month- 15 year age using MR vaccine starting 2017.
2. Introduce successfully MR vaccine (both doses) in Indonesia EPI programme in sustainable and phased manner
3. Prepare health workers at all levels and the community for the introduction of MR vaccine (make them ready to introduce and to accept MR vaccine);
4. Use the introduction of MR vaccine as an opportunity to reinforce and maintain high level of Immunisation coverage for all routine immunisation activities
5. To achieve Measles and Rubella elimination and CRS control by 2020

Introduction approach

It has been decided to introduce MR vaccine in 3 phases commencing from 2017 to 2018 in the following manner:

- Phase I in August 2017, at Java Island (West Java, Central Java, East Java, DKI Jakarta, Banten, Yogyakarta and Bali) as 53 % of the population
- Phase II in February 2018, at Sumatera Island (Nangroe Aceh Darussalam, North Sumatera, South Sumatera, West Sumatera, Bangka Belitung, Jambi, Lampung, Riau, Riau Island, Bengkulu) as 24% of population
- Phase III in August 2018, at South Sulawesi, Central Sulawesi, West Sulawesi, North Sulawesi, South East Sulawesi, Gorontalo, West Kalimantan, North Kalimantan, South Kalimantan, Central Kalimantan, East Kalimantan, NTB, NTT, Maluku, North Maluku, Papua, and West Papua) as 23% of the population

Selection of completed activities

1. Establishment of measles committee and rubella control in October 2015 through the decree of the MoH
2. Recommendation from NTAG for the introduction of measles and rubella to National Immunisation Programme in January 2016
3. Measles campaign through integration of measles crash programme and vitamin A for children aged 9-59 months in 183 districts with the target coverage at least 95%
4. Measles and rubella surveillance through Case Based Measles Surveillance and Sentinel Surveillance on CRS in 13 hospitals within 10 provinces
5. Strengthening of measles coverage for 2 year old children (MCv2)
6. Strengthening the laboratory network for measles and rubella