

Gavi 2020 multi-stakeholder dialogue: immunisation planning in light of COVID-19

Introduction

2020 has been marked by the unprecedented crisis caused by COVID-19. Though the longer-term trajectory of the pandemic remains uncertain, evidence shows that immunisation services in Gavi-supported countries have been disrupted. Millions of people are expected to miss out on immunisation, likely leading to a resurgence of VPDs, further exacerbating existing inequities and putting the most marginalised and poorest communities at greater risk. Gavi-supported countries have already had the opportunity to reallocate or re-programme¹ existing HSS and TCA support to respond to immediate needs presented by the COVID-19 pandemic. The Gavi Alliance is fully committed to assisting countries to restore immunisation services that have been scaled-back, brought off-track or otherwise affected during the pandemic response.

As an alliance, multi-stakeholder engagement remains key to Gavi's portfolio management approach. It is particularly critical in 2020 as a forum for engagement on how the Gavi Alliance partners and other stakeholders can support countries as they deal with the different phases of the COVID-19 pandemic and seek to maintain and restore primary health care, including immunisation services that have been disrupted. Civil society organisations (CSOs), in particular, will have a vital role to play in engaging communities to rebuild trust and demand, deliver services where there are gaps in government provision and in overcoming gender-related barriers.

Recognising the difficult operating environment and the rapidly evolving landscape currently faced by countries, and to ensure that Gavi's continuing support to the EPI programme is aligned with realities, countries are not requested to conduct a traditional Joint Appraisal in 2020. However, countries are encouraged to sustain the multi-stakeholder dialogue. This dialogue should review the immunisation programme performance in 2019, the impact of the COVID-19 pandemic on immunisation, discuss the needs for maintaining and restoring immunisation services in the context of primary health care, plan for short-term catch-up activities and, where needed, create a roadmap for further re-allocation/planning within the country's recovery plan.

The 2020 multi-stakeholder dialogue exercise

This 2020 multi-stakeholder dialogue exercise will be tailored to the country context, taking into account current constraints in terms of travel, meetings, and workload. The process will involve preparatory work on data for the review, potentially multiple exchanges with at least one event for live discussion (likely a virtual meeting), concluding with the finalisation of a report and relevant additional documents (e.g., workplan and budget for short-term response/recovery activities, roadmap for further planning). The process should be inclusive and transparent, with meaningful engagement of partners and civil society.

The 2020 multi-stakeholder dialogue report is structured as follows

- Section 1: Country situation: overview of performance of vaccine support, HSS grant implementation, PEF-TCA and other Gavi support, up to end of 2019/early 2020; pre-COVID-19.

¹ This document refers generally to the reallocation of Gavi support. Changes might also be categorized as reprogramming which is used for more significant modifications and may require to be reviewed by the Independent Review Committee.

- Section 2: Update on impact of COVID-19 immunisation service delivery and immunisation coverage (in 2020) and status of the implementation of the COVID-19 recovery plan (if relevant).
- Section 3: Discussion on priorities, immediate catch-up needs, related action plan, estimated budget and technical assistance needs. Roadmap for further analysis and re-allocation/planning in the context of the country health sector recovery plan.

Much of the information contained in sections 1 and 2 on the country immunisation programme and Gavi support is pre-filled by Gavi from existing documents and completed by the country.

1. Country situation pre-COVID-19, based on information received by Gavi

Contextual Information

PEF Tier: 1	Fragility Status: Non-fragile	4. Fully self-financing	
Indicator Name	Year	Source	Value
GNI per capita	2019	World Bank	4,050
Health Centres per 100k population	2013	WHO - GHO	3.4
Nurses/Midwives per 1000 population	2018	WHO - GHO	24
Population	2020	UNPD	273,523,621
Surviving Infants	2020	UNPD	4,689,610
Under-5 mortality (per 1000)	2018	UNICEF	25

Health financing (and trends)

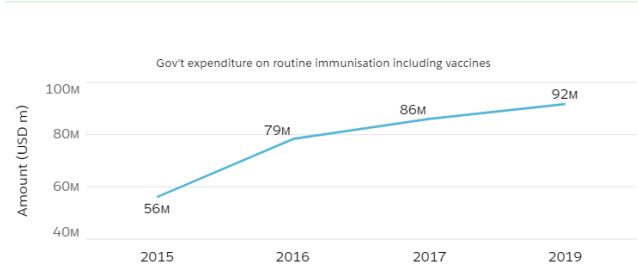


Figure 1 Indonesia situation pre-COVID-19

Indonesia is the fourth largest populous country with more than 266 millions people residing across a 17,000-island archipelago, and approximately 88 percent of them are Muslim. The economic growth of the country seems to be stable with more than 5 percent per annum for the past few years and it is being considered lower-middle-income county.

Indonesia continues to pose significant economic growth recently. The gross national income (GNI) per capita has risen from \$3,620 in the year 2014 to \$4,050 in the year 2019. Total population in Indonesia in 2020 is 273 million. Total number of surviving infants to be vaccinated each year is around 4,6 million. However, about 10 percent of the total population still live below the poverty line, and approximately one-fifth of households remain vulnerable to falling into poverty, as their income remains just marginally above the national poverty line ²

The country has made notable progress in improving the country's health and nutritional status. Maternal mortality ratio (MMR) and infant mortality rate (IMR), under-five children, stunting, and the burden of communicable disease have all reduced. The MMR had dropped from 346 deaths per 100,000 live births in 2010³, to 305 deaths per 100,000 in 2015⁴, and IMR had fallen from 32 deaths per 1,000 live births in 2012 to 24 deaths per 1,000 live births in 2017.⁵

However, inequity remains a major concern across the country by different determinants, and the immunization coverage has been plateaued over the last few years. While geographical inaccessibility remains a key driver to immunity gaps, multiple other health systems, and sociocultural determinants influence coverage, including a rapid pace of urbanization with concurrent overlapping vulnerabilities and emerging issues related to religious beliefs and vaccine hesitancy⁶. As a result, outbreaks of vaccine-preventable diseases often occur, and children are incredibly vulnerable, especially in pockets with low immunity profiles.

² The World Bank in Indonesia 2019: <https://www.worldbank.org/en/country/indonesia/overview#1>

³ Indonesia-Population Census 2010

⁴ BPS, Bappenas, UNFPA. Proyeksi Penduduk Indonesia Hasil SUPAS 2015. Jakarta; 2018.

⁵ Indonesia Demographic and Health Survey 2017

⁶ The Indonesia Demographic and Health Survey, 2017.

1.1. Overview of performance of vaccine support

Table 1 Overview of vaccine support

Vaccine	Introduction Date	2018 Coverage (%)	2019 Coverage (%)	2019 Target	2020 Target
PENTA	07-2013	85	85	-	-
IPV	07-2016	62	76	-	85

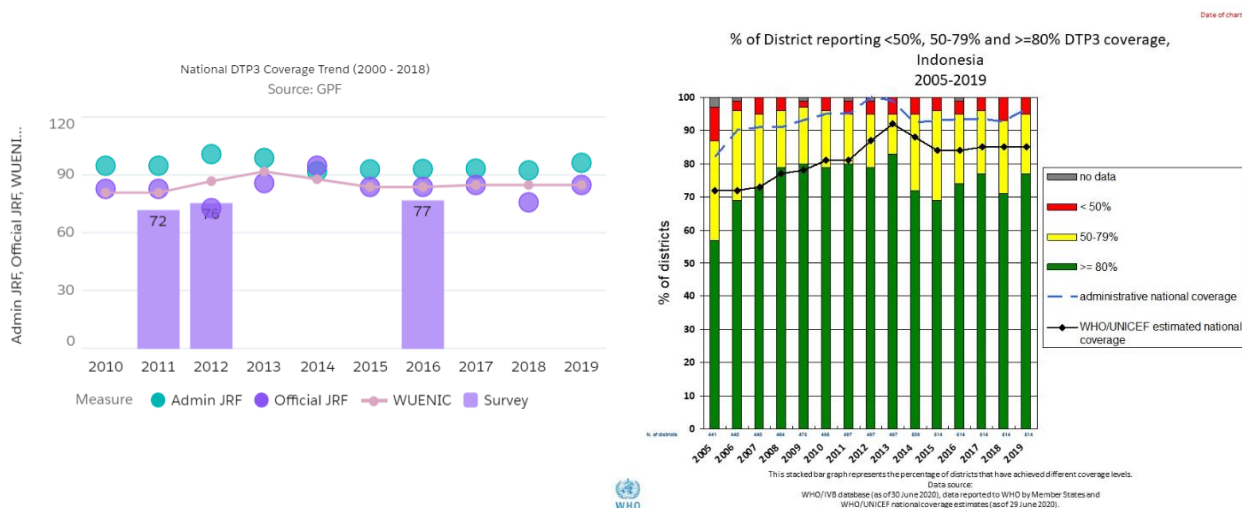
Performance against Alliance KPIs

Table 2 Performance against Alliance KPIs

Indicator	Source Name	Year	Value	Previous Value	Trend
Measles containing vaccine (second dose) coverage at the national level (MCV2)	WUENIC	2019	71	67	▲
Pentavalent 3 coverage at the national level (Penta 3)	WUENIC	2019	85	85	→
Drop-out rate between Penta1 and Penta3	WUENIC	2019	5,6	5,6	→
Difference in Penta3 coverage between children of urban and rural residences	Survey	2019	0	0	→
Difference in Penta3 coverage between the highest and lowest wealth quintiles	Survey	2019	0	0	→
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	Survey	2019	0	0	→
EVM	EVM	2015	70.6	67	▲
# of Underimmunised Children	Calculated	2019	707287.95	711646.5	▲

Trends and district equity

Table 3



Progress against indicators and targets achievement

Vaccine programme performance

Vaccine Programme	Source (2019)	Intermediate results Indicator	Reported actuals	Rel. % change
PENTA	Admin (JRF)	Number of surviving infants who received the first recommended dose of pentavalent vaccine (Penta1)	4,591,870	3%
	Admin (JRF)	Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	4,510,097	3%
MCV	Admin (JRF)	Number of surviving infants who received the first recommended dose of measles containing vaccine (MCV1)	4,448,141	2%
IPV	Admin (JRF)	Number of surviving infants who received the first recommended dose of IPV	NA	NA
All others	EVMA Reports	Effective Vaccine Management Score (composite score)	NA	NA
	JRF	Occurrence of stock-out at national or district level for any Gavi-supported vaccine	Yes	NA
	Admin (JRF) & Survey	Percentage point difference between Penta 3 national administrative coverage and survey point estimate	NA	NA

Relative % change refers to the percentage increase/decrease of the reported value from the year prior. The cell is green when the relative change increased, yellow when it remained the same and red when the relative change decreased.

1.2. Overview of CESAP grant implementation

Table 4 CESAP Implementation summary

CESAP implementation summary (as of 15 December 2020)

Recipient	Grant Amount	Funds Disbursed	Expenditure	Country cash balance
MoH	10,612,970	8,400,767	480,378	1,731,826 ⁷
WHO	4,313,559	4,031,364	836,748	3,194,616
UNICEF	2,276,129	217,693	971,325	1,087,111
Total	17,202,658	12,649,824	2,288,451	6,013,553

⁷ US\$ 13,886

CESAP key milestones achieved in 2019

Structured based on grant objectives or GPF indicators (*graph prepopulated by the CMM team*)

Process Indicators			Intermediate Results		
Indicator name	Value	Rel. % change	Indicator name	Value	Rel. % change
(CESAP) % of private health providers trained which conduct immunization session & immunization coverage report to DHO/puskesmas according to standard immunization guideline in selected urban area.	77	NA	(CESAP) number of private health providers conduct EVM practices according to standard EVM guideline in selected urban area (DKI Jakarta, West Java, Banten, East Java, Central Java).	305	NA
(CESAP) percent of caregivers who expressed lack of information as a reason for their child's incomplete or no vaccination through regular monitoring (and inclusion in survey protocol as necessary)	67	NA	(CESAP) percent health facilities previously unequipped now equipped with CCE	92	NA
(CESAP) percent of suspected VPD cases with adequate investigation (per case definition, with case investigation form, collection of specimen)	22	NA	(CESAP) Percent of Public Health Laboratory (PHL) that are meet accreditation standard as national laboratory by WHO	33	NA
OBJ-NA	NA		Number of priority districts/cities in 10 provinces implement immunization web based RR	11	↓, -65%
	NA		Numbers of priority districts in 10 provinces with low immunization coverage that achieve coverage of DPT-HB3 ≥ 80%	27	↓, -7%
	NA		Percentage of cold chain equipment that are functional according to the national cold chain inventory list	92	--, 0%
	NA		Percentage of midwifery and nursing schools or institutions are using or incorporating teaching modules on immunization in the curriculum	51	--, 0%
	NA		Proportion of Health Facilities in 31 priority districts, 10 PHOs and central level have sufficient stocks of any antigen during resupply period according to national EVM standards	64	↓, -36%

Relative % change refers to the percentage increase/decrease of the reported value from the year prior. Value cell color is green if target has been ≥ 90% met, yellow if 70-90% met, and red < 70% met.

1.3. Overview of other Gavi support, such as VIGs, OPS, post transition grants etc.

Table 5 Overview of Other Gavi support

	Start Date	End Date	Recipient	In US\$				Status Update
				Grant Value	Disbursed	Expenditure	Cash balance	
<i>IPV VIG</i>	2014	31 Dec 2021	MOH	3,688,500	2,878,704	150,474	659,049	On progress
<i>MR VIG</i>	15 May 2018	31 Dec 2020	WHO*	2,734,375	2,555,491	1,937,056	618,435	On progress
	1 May 2018	30 Apr 2019	UNICEF	1,180,008	1,180,008	1,179,294.84	713.16	Closed
<i>JE VIG</i>	22 Mar 2017	31 Dec 2020	MOH	100,000 (additional 150,000 from CESAP)	70,893	23,042	6,065	To be closed
<i>HPV Cash Support</i>	2017	31 Dec 2020	MOH	170,000	125,810	25,399	18,791	To be closed
<i>Post Transition Grant</i>	15 March 2020	15 March 2020	UNDP	2,365,959	2,365,959	749,500 ⁸		

*MR VIG from WHO will be implemented in 2021

Post Transition Grant

SMILE is now able to provide data on occurrence of stock out at the district level for any Gavi-supported vaccine. Indonesia is one of the few pioneer countries which conducted an effective vaccine management (EVM) assessment independently at both public and private sectors using tool 2.0. The overall composite score of the public sectors was 78 per cent while it was only 69 per cent in the private sector. However, the results showed a slight improvement compared to the 2015 assessment results, and yet to reach the global benchmark score of 80 per cent. The report identified several areas for further improvements, such as temperature monitoring, stock management, and storage capacity. MOH developed a continuous improvement plan based on the EVM results and recommendations. UNICEF also supported an independent assessment to identify the challenges and bottlenecks towards a unified e-LMIS system. The MOH intends to use the recommendation to develop an improvement plan to improve the performance of the immunization supply chain system.

Further more, SMILE already implemented in 100 health facilities in 2019 and in 2020 was planned in 600 health facilities in West Java Province (South Tangerang and Bogor city) and DKI Province (all cities).

⁸[Committed up to 31 December 2020](#)

Abnormality type: Zero stock
 Metric: Number of events

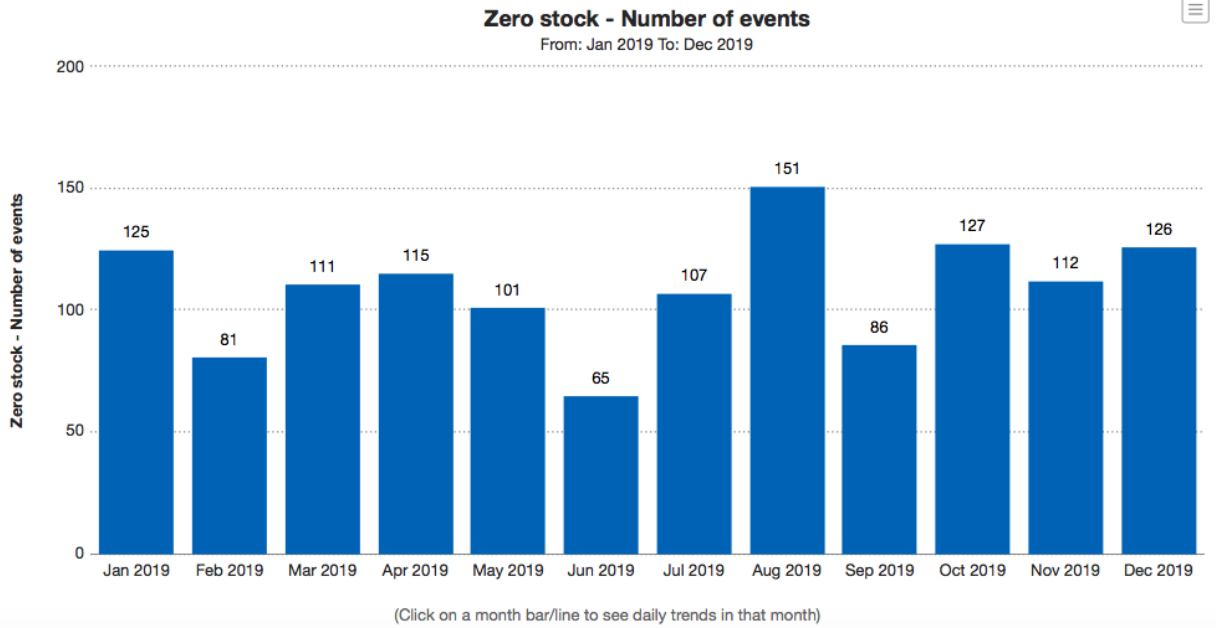


Figure 2 Zero Stock Report from SMILE Dashboard (2019-2020)

(Source: SMILE report on number of events of zero stocks in 2 districts, January – December 2019)

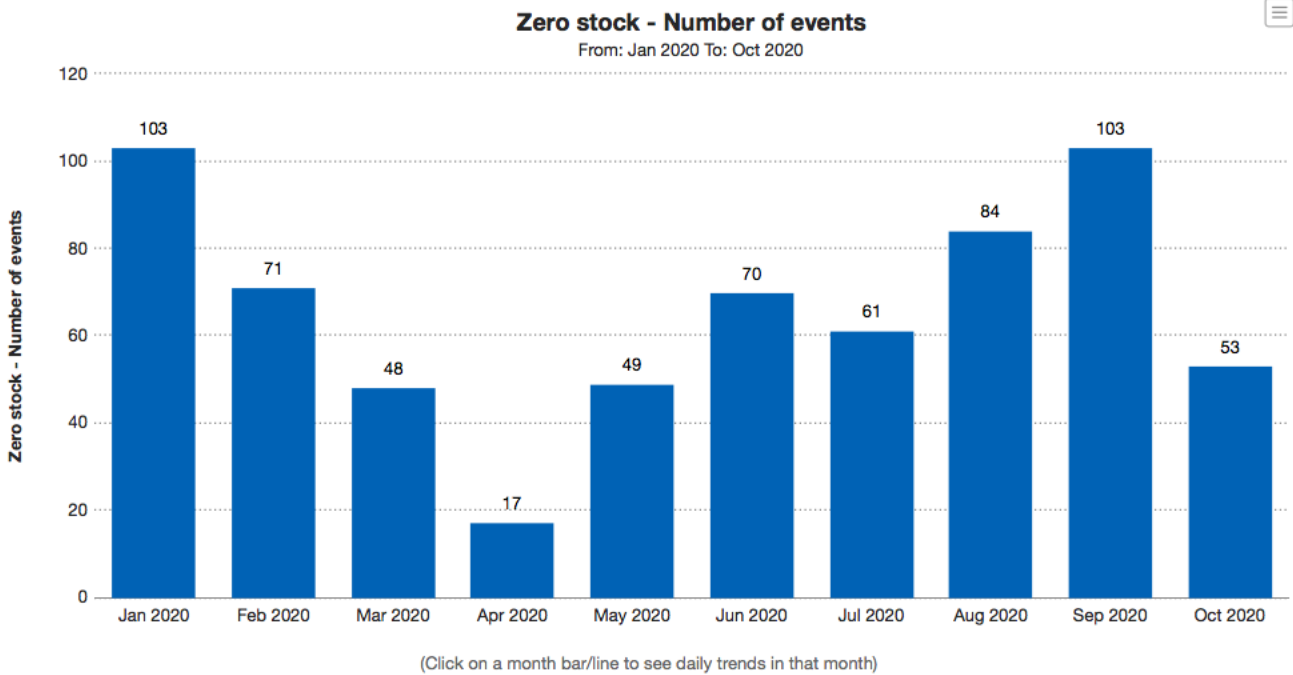


Figure 3 Zero stock report from SMILE Dashboard (2019-2020)

1.4. Compliance, absorption and other fiduciary risk matters

- Comments on financial absorption as of [date]:
- Compliance with financial reporting requirements (periodic/annual financial reports, audits):
- Compliance with programmatic reporting requirements (GPF):
- Other financial management and fiduciary risk comments:

As 20 December 2020 the financial absorption from MoH up till 78% under CESAP, VIG IPV, VIG JE, and Cash Support HPV, lower than last year which is up till 80%. Financial absorption declined due to COVID-19 pandemic, because some activities were cancelled and conducted by virtual meeting so that some budgets were cut. All activities under CESAP for MR support were cut and will be carried over in 2021 in line with MR Campaign 2021 for outside Java island.

The financial reporting requirements such as financial status, annual financial reports for 2020 would be submitted by online in Gavi portal. However, the audit of annual financial reports for 2018 and 2019 just completed by the 10 December 2020, we are still waiting for the final report from BPKP (external audit for MoH).

The updating Grant Performance Framework describe below (as update as 23 October 2020) :

Reporting Year	Pending Issue (Aug 20)	Data Point Type Missing	SKIPI/EPI input
2018	Number of children in the target population who received a recommended dose of measles-rubella containing vaccine (campaign)	Result	23.453.882 (73,38%)
2019	Number of girls in the target population who received the first recommended dose of HPV vaccine as part of the HPV Demonstration programme	Target	22.070
2019	Number of girls in the target population who received the last (either second or third) recommended dose of HPV vaccine as part of the HPV Demonstration programme	Target	15.100
2016	Number of priority districts/cities in 10 provinces implement immunization web based RR	Result	8
2018	Number of priority districts/cities in 10 provinces implement immunization web based RR	Result	12
2019	Number of surviving infants in HSS targeted areas/populations who received the third recommended dose of pentavalent vaccine (Penta3)	Target	979.237

2016	Numbers of priority districts in 10 provinces with low immunization coverage that achieve coverage of DPT-HB3 \geq 80%	Result	26 districts
2018	Numbers of priority districts in 10 provinces with low immunization coverage that achieve coverage of DPT-HB3 \geq 80%	Result	26 districts

2019	Pentavalent 3 coverage in HSS targeted areas/populations	Target	<p>80%</p> <p>Results from 10 provinces in 31 districts</p> <p>West Java (5): Bogor : 95.3% Bandung: 109.1% Bekasi: 97.4% Garut: 104% Karawang: 105.3%</p> <p>Banten (5): Serang: 113% Pandeglang: 100.6% Tangerang: 102.5% Lebak: 98.1% Kota Tangerang: 96.1%</p> <p>North Sumatera (3) Kota Medan: 94.8% Deli Serdang: 97.3% Langkat: 85.3%</p> <p>DKI Jakarta: Jakarta Timur: 98.8% Jakarta Barat: 99.3% Jakarta Utara: 96.6</p> <p>West Sumatera (2) Kota Padang: 89.7% Pesisir Selatan: 96.4%</p> <p>East Java: (5) Kota Surabaya: 97.8% Bangkalan : 73.9% Sampang: 93.5% Pamekasan: 94.2% Sumenep: 104.7%</p> <p>Central Java (1) Brebes: 109.6%</p> <p>West Kalimantan (2): Kubu raya: 84.3% Sanggau 100.8%</p> <p>Aceh (3) Aceh Timur: 49.4% Bireun: 40.7% Aceh Besar: 45.1%</p>
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South Sulawesi (2):
Kota Makasar: 96.3%
Gowa: 101.1%

2016	Percentage of cold chain equipment that are functional according to the national cold chain inventory list	Result	79%
2018	Percentage of cold chain equipment that are functional according to the national cold chain inventory list	Result	85%
2018	Percentage of cold chain equipment that are functional according to the national cold chain inventory list	Target	85%
2019	Percentage of cold chain equipment that are functional according to the national cold chain inventory list	Target	90%
2016	Percentage of midwifery and nursing schools or institutions are using or incorporating teaching modules on immunization in the curriculum	Target	51 institutions (100%)
2017	Percentage of midwifery and nursing schools or institutions are using or incorporating teaching modules on immunization in the curriculum	Target	51 institutions (100%)
2018	Percentage of midwifery and nursing schools or institutions are using or incorporating teaching modules on immunization in the curriculum	Result	51 institutions (100%)
2018	Percentage of midwifery and nursing schools or institutions are using or incorporating teaching modules on immunization in the curriculum	Target	51 institutions (100%)
2019	Percentage of midwifery and nursing schools or institutions are using or incorporating teaching modules on immunization in the curriculum	Target	51 institutions (100%)
2016	Proportion of Health Facilities in 31 priority districts, 10 PHOs and central level have sufficient stocks of any antigen during resupply period according to national EVM standards	Result	85% Stock out BCG
2018	Proportion of Health Facilities in 31 priority districts, 10 PHOs and central level have sufficient stocks of any antigen during resupply period according to national EVM standards	Result	100% (no stock out)

2018	Proportion of Health Facilities in 31 priority districts, 10 PHOs and central level have sufficient stocks of any antigen during resupply period according to national EVM standards	Target	100%
2019	Proportion of Health Facilities in 31 priority districts, 10 PHOs and central level have sufficient stocks of any antigen during resupply period according to national EVM standards	Target	6,5% IPV Stock out

2. COVID-19 impact on immunisation (in 2020): current situation

2.1 COVID-19 cases and deaths (as of 20 December 2020)

The government announced the first confirmed case of COVID-19 in Indonesia in early March 2020. Within a month, other cases had also been reported from 34 provinces. As of 20 December 2020, Indonesia has reported 664,930 COVID-19 confirmed cases. In subnational level, DKI Jakarta, East Kalimantan and West Papua are in the top three of confirmed cases per 1 million population with 15,323; 6,349; and 5,854 respectively. Active cases which are defined as cases who are still in isolation and treatment is 103,239 (15.5% from total of confirmed cases nationally).

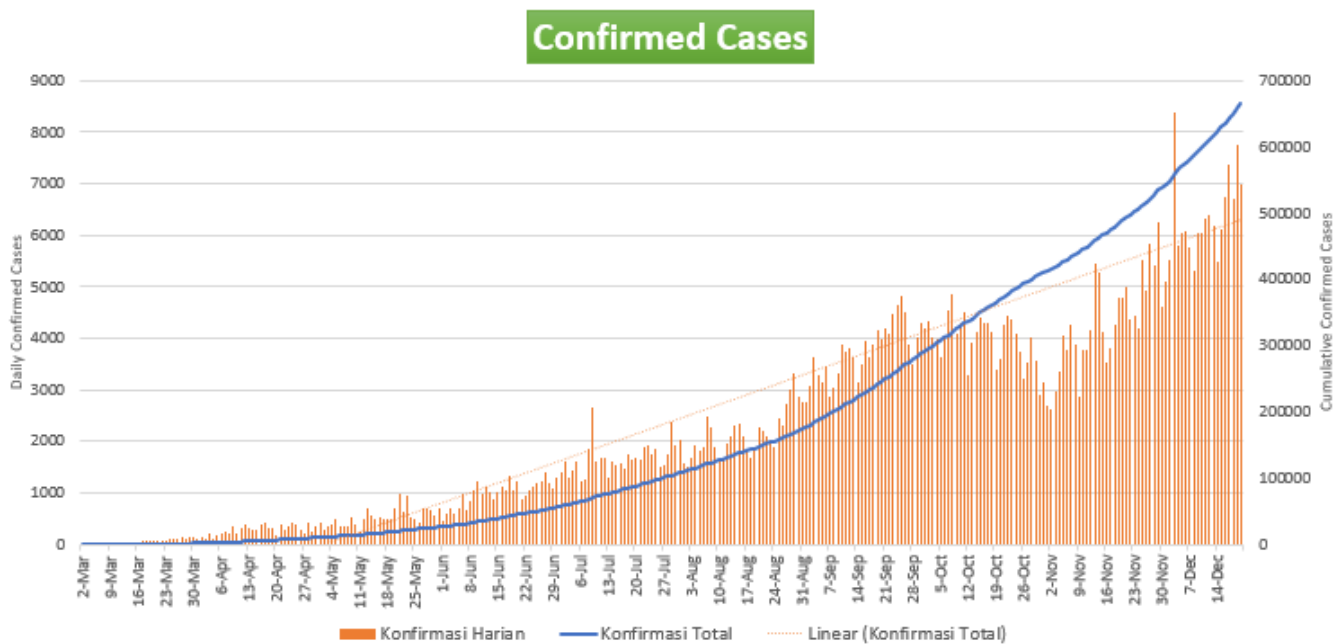


Figure 4 COVID-19 Confirmed Cases in Indonesia

There are 19,880 deaths among confirmed cases reported with CFR of 3.0% nationally. East Java, South Sumatera and West Nusa Tenggara were reported to have the highest CFR among other 34 provinces with 6.9%; 5.3% and 4.9.% respectively. Table 5 below shows CFR categorised by age group.

Table 6 Case Fatality Rate (CFR) of COVID-19 categorized by age groups

Age-group	#death	#confirmed cases	CFR %
0-5	187	17432	1.1
6 -17	367	56817	0.6
18-30	1197	158829	0.8
31-45	2973	196277	1.5
46-59	6930	148499	4.7
>60	7663	67147	11.4

2.2 Disease Surveillance and Incidence

[Information from CCM team and/or https://www.who.int/immunisation/monitoring_surveillance/data/en/]

Impact of COVID-19 on disease surveillance

COVID-19 Pandemic in 2020 has a strong impact on VPD surveillance. Figure 2 below shows a declined number of MR suspected cases in 2020 compared to year 2019. Cumulatively, there is 54% decline in case findings compared to 2019. The main reason is surveillance officers at national and subnational level are fully occupied with COVID-19 surveillance responses including budget repurposing.

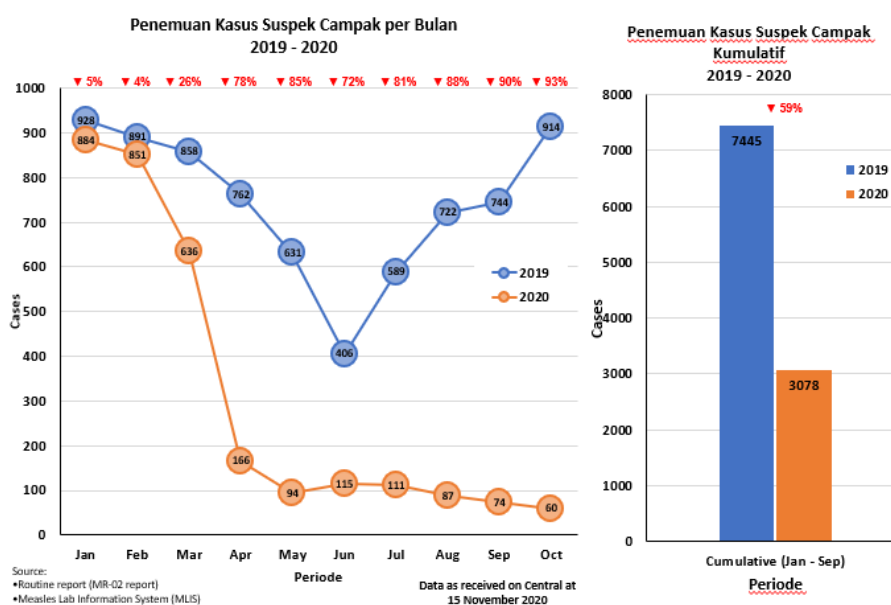


Figure 5 Trend of MR suspected case findings in 2019-2020

As a consequence, MR discarded rate is also decreasing from 1.90 in 2019 to 1.01 in 2020, still far from the target of 2/100.000 population per year. At sub national level, only 3 provinces achieved this target i.e DKI Jakarta, Yogyakarta and Central Java. All of the provinces considered as pocket areas of unvaccinated children also have not yet achieved the target which raise a concern of undetected measles-rubella cases in the area.

Impact of COVID-19 on disease cases

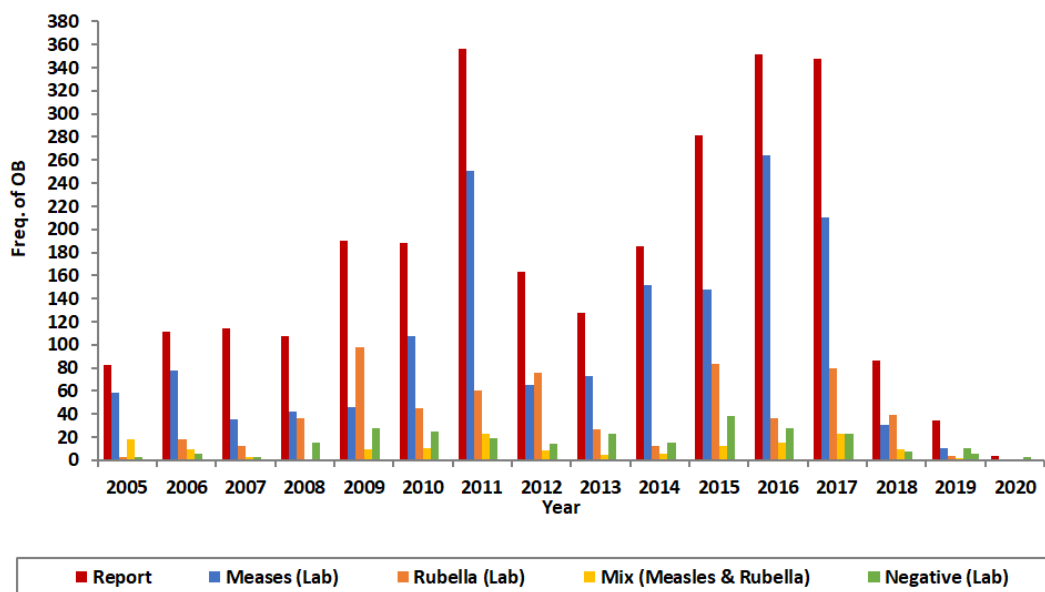


Figure 6. Measles outbreak reported and laboratory confirmed from 2005-2020

Figure 6 above shows decline in measles and rubella outbreak from 2005-2020. In 2020, there is only 1 laboratory confirmed case outbreak reported from Aceh. However, this figure cannot be interpreted correctly especially in 2020 due to low sensitivity (discarded rate <math><2/100.000</math> population) in both national and sub-national level. There may be more undetected cases.

2.3 Impact of COVID-19 on immunisation

Briefly describe the impact that COVID-19 has had on your ability to effectively deliver immunisation services, using available comparative admin coverage data/perception surveys/rapid assessment, including:

- *Constraints on routine immunisation services (e.g. are health workers still carrying out immunisation services? What barriers do health workers face?)*

Rapid Assessment and Survey: To assess the effects of COVID-19 pandemic on immunization, MOH supported by partners conducted several national surveys starting from April – July 2020 with correspondent health workers and parents. A national online health worker survey was conducted four to six weeks after COVID-19 confirmation across 5,329 primary health care (PHC) facilities (53% of total) in all provinces, including 388 of 540 districts. The assessment highlighted the severity of service disruptions across the country, regardless of the distribution of the COVID-19 cases. It recommended conducting another study to understand the perspectives of the parents and caregivers. In conjunction with the recommendation, another survey to understand community perceptions of immunization services during the COVID-19 pandemic was carried out from 4 to 13 July 2020 across all 34 provinces in the country. The survey has gathered responses online from nearly 7,000 parents and caregivers of children under the age of two who were reached by SMS through the national taskforce for COVID-19.

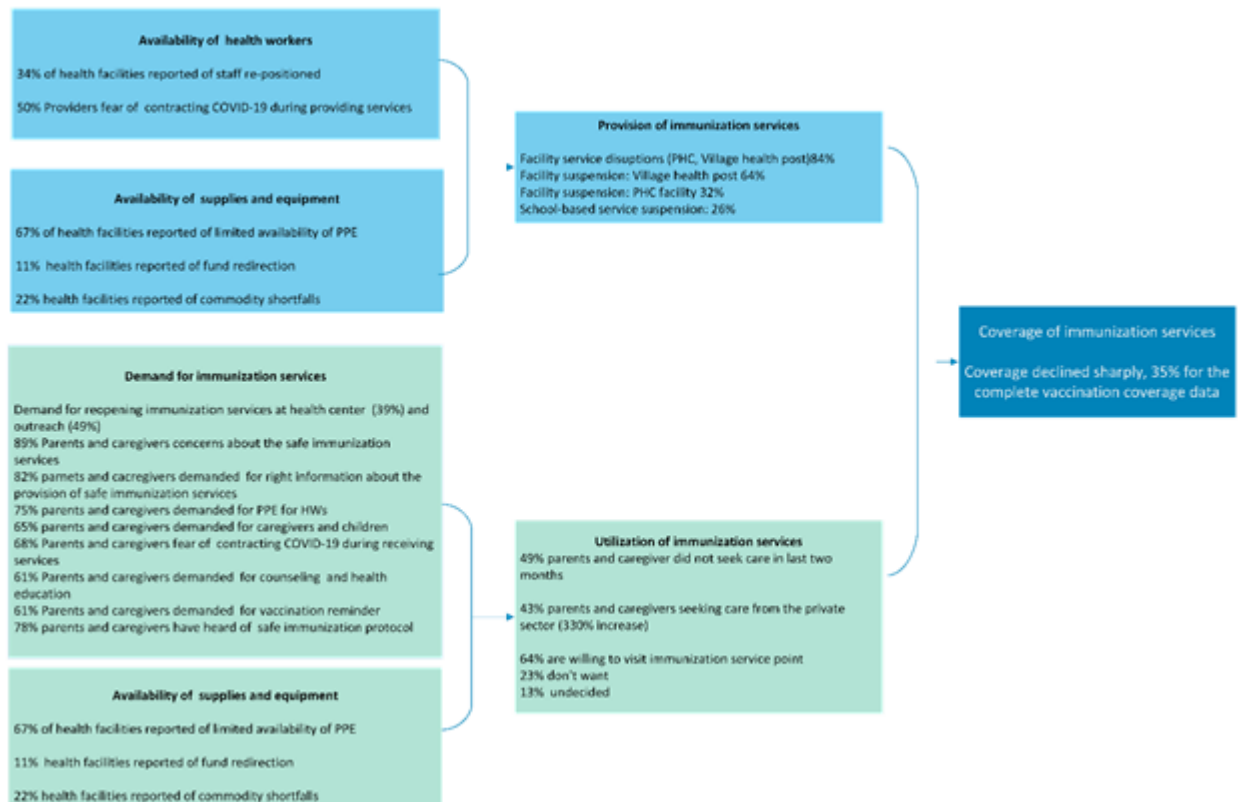
A sharp reduction in the vaccination coverage: Since Indonesia reported the first COVID-19 case in March 2020, coverage of routine immunization to prevent childhood diseases such as measles, rubella, and diphtheria has been declining. For example, complete vaccination coverage rates reduced by 20% in September 2020 compared to the same period in the previous year. There is a decrease of DPT3 coverage from March to October, with the largest difference in May. From June to October, the coverage is increasing. There is a 20% gap between DPT3 coverage in September 2019 (82.3%) and September 2020 (65.6%). There is a decrease of MCV1 coverage from March to October, with the largest difference in May. From June to October, the coverage is increasing. There is a 19% gap between MCV1 coverage in October 2019 (80.3%) and September 2020 (65.4%). See figure

Decline in routine immunization coverage ranging from 10 to 40% across different vaccines, in March – October 2020 compared to 2019 in similar period. DPT3 coverage is 20% lower with more than 600,000 infants were missed since Jan – October 2020:

- 69.12% immunization officers in 70 districts were repurposed immunization officers to the COVID-19 response based on dashboard monitoring of EPI and VPD surveillance during COVID-19 pandemic.
- Dashboard also showed large-scale social restrictions (PSBB) have led to a decline in vaccination services in many regions due to limitations in movement and closure of transportation, including vaccine distribution. However, stockpiling in health centres is also likely occurred due to halt of immunization service
- 49.2% health centers in 70 districts informed that their budget for immunization service has been repurposed to COVID-19 response from the monitoring dashboard <https://datastudio.google.com/reporting/5fa48f33-7bc3-4d01-8236-66d5d9e2e2d1/page/n2GOB?s=IZ1XUohiGi4>

Rapid assessment on impact of COVID-19 pandemic on immunization in April 2020 showed immunization services are disrupted in more than 90% of total posyandu and 65% of total puskesmas. It captured health staff's concern about contracting COVID-19 while performing immunization services. Similar concerns were shared by caregivers where they are afraid on COVID-19 transmission during immunization service.

- Several factors that cause disruption of immunization services and decline in immunization coverages were identified as follows:
 - Restrictions on outreach immunization services. In some areas, Posyandu are even closed at all
 - Parents are reluctant to bring their children to be vaccinated, due to fears on COVID-19 transmission
 - Operational costs for immunization service implementation and immunization human resources in most districts have been shifted to support pandemic control efforts
 - Private clinic closure, school closure, restriction of transportation due to large scale social movement restriction (Pembatasan Social Berskala Besar/PSBB)s
 - Shortage of PPE such as mask, gloves, face shield for health workers and kaders affected the EPI service delivery. (NITAG Report, 2020)



Provision of immunization services: The results of survey showed that 84% of all health facilities reported immunization service interruption at both fixed and outreach sites. Disruptions in immunization services were substantial and immediate, with bottlenecks observed at multiple levels. Access barriers from service suspensions were compounded by health workers' fear of contracting COVID-19. The survey found supply constraints resulting from redirecting immunization staff and resources towards COVID-19, limited availability of personal protective equipment (PPE) for safe immunization, and commodity shortfalls.

Utilization of Immunization Services: The perception survey found that public behaviors and practices of seeking immunization services have been significantly altered. Most parents and caregivers were concerned about the safety of their children during vaccination and demanded immunization services with high quality and adequate safety. Prior to COVID-19, around 90 per cent of children in Indonesia were vaccinated in public health facilities, including health posts (posyandu), health centres (puskesmas) and village birth facilities (polindes).

According to the survey, half of responding parents and caregivers brought their children for routine immunization over the past two months, with the other half not attending immunization sessions either due to the conditions created by the COVID-19 pandemic or because their children did not need a vaccine in the given timeframe. However, a majority of respondents – 43 per cent – indicated that they are now seeking childhood immunizations in private clinics and hospitals due to closures of government-run or public health facilities, including outreach sites in their area.

While the survey highlights the unavailability of immunization services caused by disruptions to the health system, it also reflects high demand for vaccines, with parents and caregivers exploring alternative service points that offer immunization services. Respondents reported feeling reluctant to visit health facilities due to fear of contracting COVID-19 and raised concerns about the closure of immunization services, especially at posyandu and community levels.

Parents and caregivers also reported high out-of-pocket expenditure for obtaining vaccinations at private health facilities, which are otherwise free of charge at public facilities.

- *Impact of the pandemic that may have exacerbated gender related barriers to immunisation experienced by caregivers, adolescents and/or health workers.*

A report released in October 2020 by UN Women, “Counting the costs of COVID-19: Assessing the impact on gender and the achievement of the SDGs in Indonesia”, highlighted that the pandemic had exposed women's vulnerability to economic shocks and had deepened the gender inequality that existed in Indonesia decades before the pandemic. The study found that female employees had seen their working hours cut by 50 per cent, whereas male employees only saw a 35 per cent cut in their working hours. The health crisis had also added to women's burdens even as their incomes continued to decline, with many women having to juggle their professional responsibilities alongside household chores and increased parental responsibilities, as they could no longer afford child care services including immunization. These impacts were likely to reverse progress in achieving the immunization targets set forth in the cMYP and RPJMN.⁹

- *Impact on uptake, demand and community engagement (including impact of rumours or misinformation)*

Health System's Responses in Indonesia: The Government of Indonesia (GOI) has taken several measures to ensure the containment of the virus and reinforce the capacity of the health system to manage such a pandemic. Immediate service resumption has been considered key to reducing vaccine-preventable diseases. The MOH has developed and socialized a series of guidelines, standard operating procedures (SoP), and information, education, and communication (IEC) materials for immunization services during COVID-19 pandemic through webinar, social media, etc. The Ministry of Health (MOH) issued guidelines, circulars and information, education and communication (IEC) materials to continue immunization services based on global guidance issued by the World Health Organization (WHO). These materials emphasize continuing routine immunization services while maintaining physical distancing and other infection prevention and control measures. Health workers play an important role to increase parents and community knowledge and understanding, build trust and credibility and the creation of appropriate attitudes, behaviours and beliefs about routine immunization information during the COVID-19 pandemic.

The MOH, along with partners, has been continuously advocating at national and sub-national levels for strengthening the immunization program during COVID-19 through: a) resuming immunization services; b) earmarking adequate budget for the immunization program, including the catch-up activities – Polio SIA using IPV in North Kalimantan provinces has been started since 5 October 2020 as a mitigation effort in the border area to prevent cVDPV-2 transmission from polio outbreak in Sabah, Malaysia. The target of SIA is 198.044 children between 4 months to 15 years old. MR SIA in selected provinces is planned in 2021 – during the prolonged pandemic situation; c) ensuring sufficient human resources; d) equipping health workers with adequate PPEs as per MOH protocols; and e) undertaking innovative and contextual social mobilization approaches for regaining communities' trust in the health system.

Based on the perception study findings, the National Technical Advisory Group on Immunization (NITAG), WHO and UNICEF have recommended the GOI addressing the people's concerns through an immediate resumption of immunization services under the MOH safe immunization guideline, ensuring adequate logistics for vaccinators, providing information to the community

⁹ <https://data.unwomen.org/publications/counting-costs-covid-19-assessing-impact-gender-and-achievement-sdgs-indonesia>

about the delivery of safe immunization services and strengthening the coordination and collaboration between private and public sectors.

The Ministry of Home Affairs has issued a circular letter to all provinces highlighting the importance of maintaining immunization interventions and the MOH has reprogrammed part of its budget to purchase PPE for vaccinators so that immunization services can safely continue at the community level. To ensure children continue to receive routine immunizations during the pandemic, the MOH with support from partners will continue to expand targeted outreach efforts to communities so that parents and caregivers are aware these services are safe and still available in public facilities. Advocacy that investments in immunization are crucial and safe, should also be accelerated to prevent and end parental hesitancy to immunize their children.

- *Impact on any planned new vaccine introductions or campaigns*

As stated in the cMYP 2020 – 2024, EPI plans to continue the introduction and expansion of new vaccines in Indonesia. This includes gradual expansion of HPV, PCV, and JE vaccine as well as potential introduction of Rotavirus vaccine. New vaccine introduction (NVI) is a critical priority to EPI given pneumonia and diarrhea remain as the leading causes of death among under five in Indonesia.¹⁰ The high economic impact of these vaccine preventable diseases has also become a serious burden for the country, with the government spending up to US\$2.5 million for cervical cancer treatment only.¹¹ This has led to EPI's commitment in obtaining ITAGI recommendation and securing endorsement for new vaccine expansion following global commitment within GVAP.

COVID-19 pandemic put NVI effort temporarily on hold as EPI needed to balance the agenda to maintain services and recover routine immunization coverage, with the need to resume its NVI agenda. HPV and PCV introduction were initially planned for expansion to new areas in 2020. HPV was meant to follow an expansion scenario of 2 districts per year, moving to Karanganyar and Sukoharjo in Central Java this year. Similarly, PCV was planned to be expanded to 2 provinces, West Java and East Java this year. The scale up plans are still expected to proceed albeit with some delays.

For PCV, EPI has secured Ministerial Decree for expansion in June 2020 and now waiting for vaccines to be procured through AMC. Budget allocated for PCV procurement are also secured, despite budget rationalization across the Ministry of Health for COVID-19 response. It reflects the government's commitment towards PCV introduction. The 2 planned provinces, combined with 2 existing demo provinces, would altogether cover 34% of Indonesia's birth cohort. At this scale, every year of earlier introduction would avert 2,239 deaths and save US\$5.6 million treatment cost.¹² Partners are rallying to support the government in ensuring successful PCV introduction. CHAI is working with EPI on planning and preparation for roll-out, while UNICEF is supporting the PCV procurement process through the Supply Division.

For IPV, the MOH and North Kalimantan PHO launched the **IPV SIA** in October 2020; however, the launching schedules at district level were adjusted based on the local situations of the COVID-19 outbreak. Several Puskesmas with high case rates were shut down pursuant to the local policies in response to the COVID-19 pandemic. The MOH developed technical guidelines, booklets for health staff and cadres, posters design and immunization cards, and different IEC

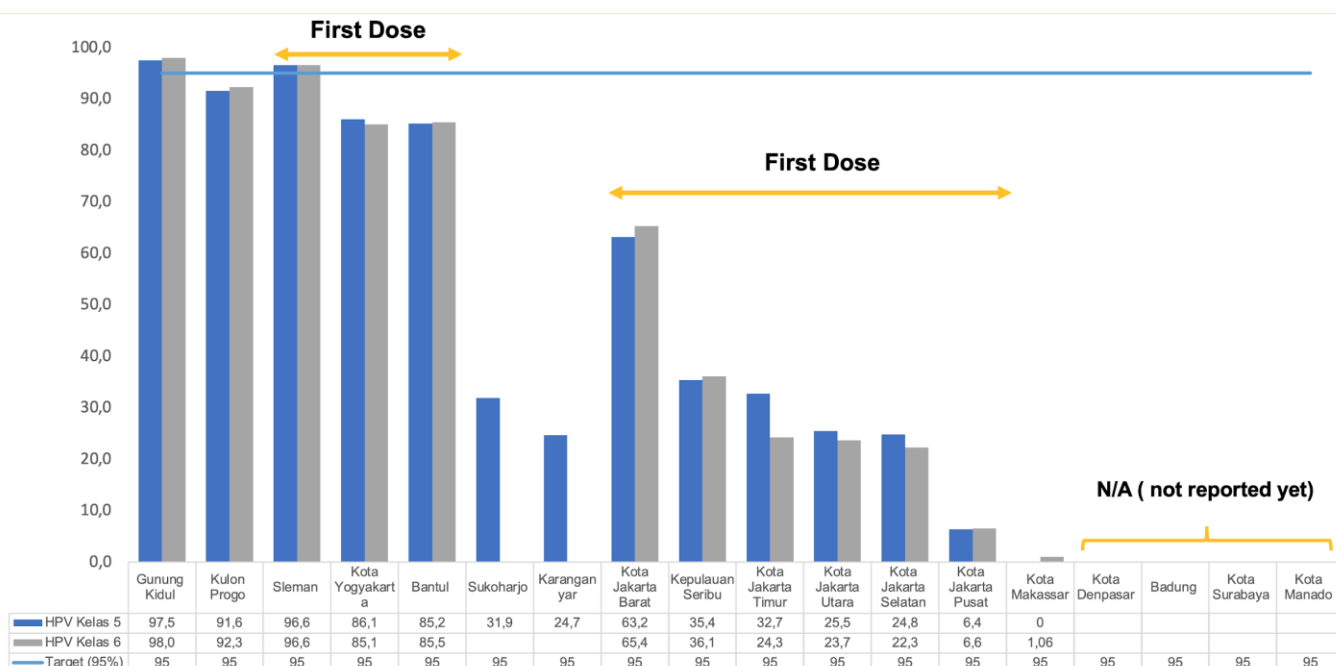
¹⁰ UNICEF, 2019, <https://stopppneumonia.org/wp-content/uploads/2019/11/Indonesia-12.11.2019-Web.pdf>

¹¹ Setiawan, et al. 2020. Cervical cancer prevention in Indonesia: An updated clinical impact, cost-effectiveness and budget impact analysis.

¹² Suwantika, et al. 2019. Cost-effectiveness and Budget Impact Analyses of Pneumococcal Vaccination in Indonesia.

materials. All the materials were socialized remotely and MOH with the support of partners organized different online training sessions for the health managers and workers. UNICEF has provided technical assistants (two consultants) based in North Kalimantan to support the PHO and DHOs to implement and monitor IPV SIA. As of 17th December, RapidPro recorded 123,770 out of 218 497 (56.7%) children between 4 months to < 15 years were vaccinated (denominator: MOH Data Center target). So far, none of 5 districts has reached the 95% coverage rate of the initial target. The SIA IPV is expected to continue throughout December 2020.

For HPV, the expansion of HPV immunization to Sukoharjo and Karanganyar in Central Java province in 2020 was implemented as scheduled. The expansion was in line with the plan and the Health Minister’s decree about the expansion of HPV immunization plan. HPV immunization was integrated in the BIAS program (immunization for children in school).



The decline of coverage was estimated to decline due to school closing till the end of year. Still, BIAS are conducted with each strategy at every province like scheduled immunization in school or in public health center that were supported and coordinated by school, teacher, and health officer. The HPV coverage in Central Java province as 21 October 2020 up till 31,9% for Sukoharjo and 24,7% for Karanganyar.

For MR campaign, based on the National Verification Committee for Measles Rubella Elimination/Congenital Rubella Syndrome (CRS) recommendation on October 20th 2020, the implementation of MR SIA will be carried out gradually for outside Java Island in 2021 and Java Island in 2022. The recommendation was made according to the result of Measles Rubella Risk Assessment in 2019 and by considering the impact of COVID-19 pandemic to measles rubella routine immunization. MR SIA Phase I in 2021, targeted for all provinces outside Java Island with target children aged 9 months - 12 years old, except for Aceh, North Sumatera, West Sumatera, Riau and Kepulauan Riau Province which targeted children aged 9 month - 15 years old. The target number of children for MR SIA in 2021 is 29.134.067 children. The target number may change because it is still using 2020 MoH target estimation, while the 2021 target estimation has not been released yet by MoH. This recommendation is still in the process of being reviewed by the Minister of Health. Further results of the review will be updated later.

- *Impact on vaccine stocks (e.g. restocking of vaccines and related supplies, risk of expiry, updating dose requirements, reallocating stocks internally within the country/districts to ensure equity of supply)*

Within Indonesia’s EPI programme, six of the routine antigens are produced by the state-owned manufacturer, BioFarma. Consequently, the programme has been able to maintain adequate stock levels of these vaccines throughout the COVID-19 pandemic. Notable exceptions are PCV and IPV which are procured externally, and therefore affected by overall delays in the procurement process due to competing priorities within the Ministry of Health. This is exemplified in the table below, which shows PCV stock levels in 2020 (expressed as weeks of stock) throughout Babel Province and its ensuing districts.

Table 7 PCV stock levels throughout Babel province Jan-July 2020, expressed as weeks of stock.

Province/ District	Jan	Feb	Mar	Apr	May	Jun	Jul	Stock Legend
BABEL PROVINCE	2.1	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	Overstocked
Bangka	4.8	3.1	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	Adequate*
West Bangka	5.4	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	Low Stock
South Bangka	<u>0.0</u>	2.1	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	Stockout Due
Central Bangka	7.5	4.0	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	Stockout
Belitung	7.3	1.0	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	
East Belitung	1.6	3.8	0.4	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	
Pangkal Pinang	8.2	1.5	1.5	1.5	1.5	1.5	<u>0.0</u>	
* Adequate stock is defined as stock levels which fall between the min-max levels of 4-8 weeks for district stores, and 4-12 weeks for the provincial store.								

Source: Paper reports from Babel province.

As the table shows, whilst PCV stock was held by the province and 6 of the 7 districts in January, by March the majority were stocked out, and by July there was a province-wide stockout. Prolonged stockouts can also be seen elsewhere within the country where PCV had been introduced, that is Nusa Tenggara Barat (NTB) province, which has had a province-wide PCV stockout for the duration of 2020. The province-wide PCV stock-out has resulted in 84,042 children mis-vaccinated (coverage 7%; latest data October 2020) in Nusa Tenggara Barat, and 16,182 children (coverage 20%; latest data November 2020) in Bangka Belitung province. Whilst citing the pandemic as the definitive cause of the stockout is problematic, given the multifaceted nature of procurement, the process has undoubtedly been protracted by COVID-19.

An extended stockout of IPV has also been seen throughout 2020, with both NTB and Babel reporting zero stock across all districts since February 2020. As with PCV, IPV is procured externally, and the process of rectifying ongoing regulatory issues in-country were deprioritised during the COVID-19 response period. These issues were subsequently addressed in Q3, and

a limited supply of IPV stock 300,479 vial (5-dose/vial) was received in October 2020. Data collection for targeted catch up is in progress, in parallel with catch up activities.

Despite EPI's effort to provide guidelines for services delivery during Covid19, some parents are still worried brought their child to get the vaccination in health facilities or the schools for BIAS. In Bali province, some antigens such as Japanese Encephalitis Vaccine (JEV) and Tetanus and Diphtheria Vaccine (Td) are reported with high wastage rate. So that JEV coverage updated until 20 November 2020 in Province level up till 45,9%, the decline was 29,9% compared to last year.

Table 8 Coverage JEV in Bali Province

Years 2018 (Introduction phase)				Years 2019			Years 2020		
District /City	Target	Number of Children get the immunization	Coverage (%)	Target	Number of Children get the immunization	Coverage (%)	Target	Number of Children get the immunization	Coverage (%)
Jembrana									
Tabanan	4,989	2,316	46.4	4,935	4,822	97.7	4,887	2,166	44.3
Badung	10,178	3,847	37.8	10,244	8,199	80.0	10,314	4,360	42.3
Gianyar	7,059	2,661	37.7	7,015	5,491	78.3	6,978	4,067	58.3
Klungkung	2,445	1,563	63.9	2,416	2,527	104.6	2,389	1,455	60.9
Bangli	3,258	1,831	56.2	3,222	2,637	81.8	3,190	1,904	59.7
Karang Asem	6,162	2,912	47.3	6,093	5,088	83.5	6,033	3,207	53.2
Buleleng	9,780	3,390	34.7	9,693	6,538	67.5	9,617	4,846	50.4
Kota Denpasar	16,197	2,252	13.9	16,266	9,384	57.7	16,340	4,811	29.4
Bali Province	63,946	22,542	35.3	63,732	48,308	75.8	63,566	29,151	45.9

The wastage rate was higher due to the pandemic, since the parents did not come in the session that was scheduled with the Health Center officer. Based on our findings in Province Bali at health center level, the wastage rate up till 60-80% for JEV because the vaccine that should be opened for 5 children only used for 1 - 2 children; and around 75-90% for Td vaccine which is integrated in BIAS program.

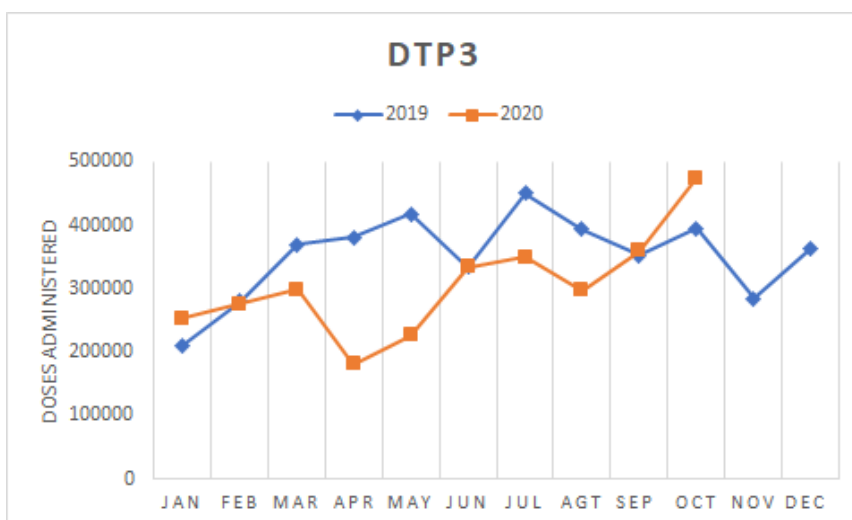
- *Impact on health and immunisation (incl. vaccines) financing (e.g. repercussions on the health/ immunisation/ vaccine budget; delays in budget disbursements relating to immunisation activities; intention of other donors to make additional funding available for health/ immunisation/ vaccines)*

The prolonged outbreak of COVID 19 has had not only a substantial burden on healthcare systems but also significant economic consequences for the affected countries. The indirect effects of COVID-19 on the health system outweigh the direct effects; more deaths are being reported of other diseases than of COVID-19. Concerns have been raised regarding COVID-19's potential to exacerbate health system vulnerabilities and reduce access to child health services. Recent models project a 9.8% to 44.7% mortality-excess in child deaths among low and middle-income countries; however, just 6% were attributable to vaccine-preventable

disease (VPD) with slightly higher estimates (9%) in Indonesia.¹³ The National Immunization Program (NIP) in Indonesia has been severely affected by the disruptions of the COVID-19 pandemic. Indonesia's first COVID-19 cases were reported in early March 2020, and the health system, in particular health service delivery in both rural and urban areas across the country, has been disrupted significantly.

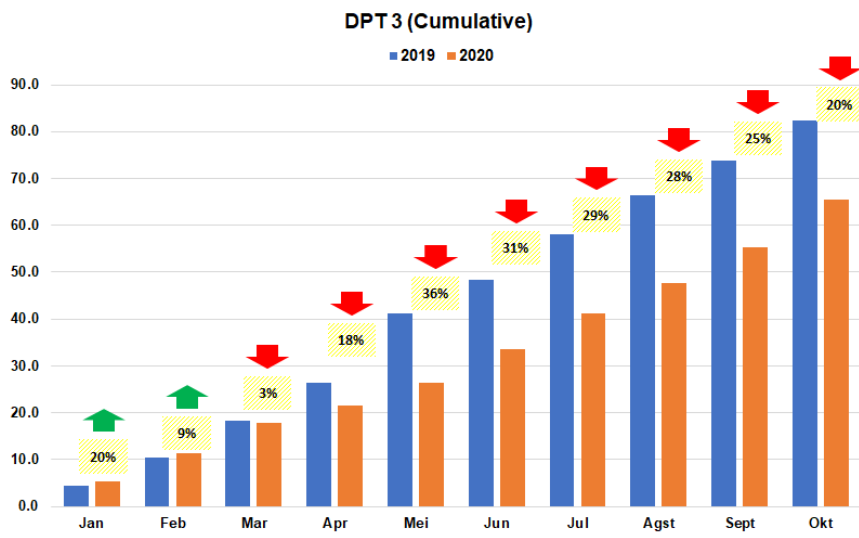
In response to the Covid-19 pandemic, the central government released presidential decree no. 54 year 2020 on budget rationalization for the 2020 fiscal year. Budget cuts did not affect vaccine procurement; however, EPI MOH experienced a significant budget cut, particularly in its operational budget. The MOH reduced allocation for immunization (APBN source) from IDR 29,5 billion to IDR4,9 billion i.e., a reduction of 83%. The following activities were particularly affected with a $\pm 30\%$ reduction in funding: Supportive Supervision, DQS, SOS, Monitoring, Logistics. The decision was made based on criteria including urgency of activities and limited opportunities for implementation amid the pandemic. Deconcentration funds (transferred from the central level to PHOs) for immunization were also reduced by 64% (IDR206,6 billion to IDR74,9 billion). The implication to program implementation was the inability to conduct planned capacity building activities for PHO, DHO, PHC staff; cancellation of some IEC activities through paid channels; and delays in operational preparatory activities to expand new vaccine introduction in some provinces.

Beyond the central level, budget rationing for the 2020 fiscal year also impacted subnational levels. In article 7, it has been stated that the central government will re-adjust transfer fund allocation to PHOs & DHOs. CHAI conducted a rapid survey in Nusa Tenggara Barat & Bangka Belitung provinces to gather information and facts about Covid-19 impact on immunization budget rationing in PHOs and DHOs. Out of 17 districts, 14 districts experienced budget cuts for immunization from both local budget (APBD II) and BOK Kesehatan (transferred fund). Cuts to local budgets (APBD II) reached 50-75%, while cuts to BOK Kesehatan ranged between 25-50%. The main types of activities were affected by the budget cuts: program management-related activities e.g., evaluation and coordination meetings; M&E and supportive supervision, capacity building for staff, and campaign activities. In addition, 2 out of 10 districts who requested procurement support, such as cold chain equipment through DAK fisik fund, experienced a delay in budget disbursement.



¹³ Robertson T, Carter ED, Chou VB, Stegmuller AR, Jacks BD, Tam Y, Sawadogo-Lewis T, Walker N. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. *Lancet Glob Health* 2020, doi.org/10.1016/S2214-109X(20)30229-1. ([LiST dashboard](#), Accessed June 3, 2020)

Figure 7 DPT3 coverage comparison 2019 – 2020



2.4 Already agreed budget reallocations of cash grants for COVID-19 response

[Please complete table to reflect any budget reallocations already approved – example below]

	COVID-19 activity	Amount reallocated (US\$)	Status of implementation
Activity 1	PPE procurement (reallocated from IPV – VIG)	45.455	Done Actual as 42,509 ¹⁴

The PPE was used to support service delivery in the province with a minimum stock of PPE. The additional number PPE had been distributed in the table below :

Province	Number
West Java	1,246
East Java	817
Central Java	987
North Sumatera	565
Banten	449
South Sulawesi	315
DKI Jakarta	308
South Sumatera	299
Riau	293
Lampung	279
North Kalimantan	915
TOTAL	6,473

¹⁴ USD 13,886

2.5 Unspent funds and savings from Gavi support, available for re-allocation

[Brief narrative and/or table. Considering that some activities have been cancelled, delayed or modified, this is an overview of funds available to be re-allocated.]

The unspent fund with UNICEF and WHO will be reprogrammed for 2021.

This report endorses the no-cost extension request of the WHO and UNICEF's CESAPs until December 2021 which are in line with the MOH's CESAP project cycle.

	Start Date	End Date	Recipient	In US\$				Status Update
				Grant Value	Disbursed	Expenditure	Cash balance	
JE VIG	22 Mar 2017	31 Dec 2020	MOH	100,000	70,893	23,042	6,065	To be closed
HPV Cash Support	2017	31 Dec 2020	MOH	170,000	125,810	25,399	18,791	To be closed
TOTAL							24,856	remaining

In 2020, MoH have allocated budget for some activities under HPV Cash support (such as the national plan for Cervical Cancer, Coverage Survey HPV and some operational support for DIY province); and VIG JE (such Cost Effectiveness Analysis and operational support for Bali province). We propose the amount 24,856 from total cash balance of VIG - JE and HPV Cash Support to be used for operational support in the plan of JE expansion in West Kalimantan, HPV expansion in Central Java (Sukoharjo and Karanganyar) in 2021.

3. Discussions on priorities, action plan and technical assistance needs; Roadmap for further re-allocation/planning

Based on the analysis of the current programmatic and financing status of your immunisation programme (captured in Sections 1 and 2), the questions below provide guidance for a multi-stakeholder dialogue.

This should result in an outline of your plans to reinforce/re-establish routine immunisation activities, catch-up on missed children, and potentially re-activate some of the planned new introductions and/or campaigns, in the context of the country epidemic response/recovery plans while taking into account the guidance provided by the Alliance.

The country is expected to:

- Define short/medium-term activities to maintain/restore routine immunisation and catch-up on coverage as needed. For these, a workplan and budget will be required.
- Define a roadmap for further re-allocating/planning of activities not captured here, considering the medium/long-term country recovery plan, domestic resources and those available from other development partners, lessons learned and innovative approaches used to cope with the epidemic, and synergies with all relevant stakeholders, including CSOs, with the vision of “building back better”.

The multi-stakeholder dialogue may consider the following questions, taking into account the latest programmatic guidance provided by the Alliance:

Short/medium-term activities to maintain/restore routine immunisation

- *COVID-19 recovery plan: does the country have a recovery plan which includes restoring essential health services including immunisation?*
 - *If not, is the recovery plan being developed? Please give a brief overview of the process and timelines for its completion. Mapping the district with highest number of unvaccinated*

Establishing catch up vaccination policy and schedule

Indonesia established two circular letters on strengthening routine immunization. In January 2020, Director General of Communicable Disease released circular letter about “Strengthening Routine Immunization in Response to Polio Outbreak in Neighbouring Countries” that recommend to provide IPV to children who were born in April 2019 and have not received 1 dose routine IPV and conduct backlog fighting which is completing routine immunization status for below 3 years children who missed their schedule. Another circular letter from Ministry of Home Affairs about “Strengthening Routine Immunization in New Normal Era” circular to all Governor and Head of Regency was released in August 2020 requesting support to ensure children completing routine immunization as per national schedule and assign sub national health office to mobilize cross sector and relevant stakeholder to improve routine immunization. Technical guidance on immunization services during COVID-19 pandemic, emphasizing adherence to health protocol to prevent COVID-19 transmission on vaccination session, defaulter tracking and monitoring coverage, has been released and updated in October 2020. Dissemination to subnational and health centres of policy and guidance is ongoing in a cascading manner.

- *Immunisation services: What strategies have been implemented at the service delivery points to re-activate immunisation services and to address any immunisation gaps resulting from COVID-19?*
 - *Are any additional strategies/delivery mechanisms planned (e.g. updated demand strategies, community outreach, PIRIs, new campaigns, etc.)?*
 - *If so, how are these measures incorporated into broader primary healthcare considerations and are they in line with WHO guidelines?*
 - *What plans exist regarding risk communication and community engagement in the response?*
 - *What lessons learned and/or innovative approaches to immunisation service delivery that were used to cope with the epidemic are worth broader adoption and scaling-up?*

Ensuring availability of vaccines and supplies

National procurement for routine immunization vaccines and supplies have not been halted. However, to avoid disruption of distribution and stockpile or stock out of vaccines and supplies, it requires quality of planning and coordination with stakeholders involved in transportation. Anticipating COVID-19 vaccine in 2021, MOH has conducted Cold Chain Inventory assessment to assess health centre, district and provincial cold chain capacity. Results showed sufficient capacity of cold chain at district level, while around 900 health centres are lacking 13L capacity if added with COVID-19 vaccine. There are two mechanisms to address this issue. Firstly, the health centre will increase frequency to collect vaccines. Secondly, is to provide a new refrigerator along with a support system (e.g. electricity, generator).

Improving health worker knowledge and practice

Adaptation of capacity building to virtual has been initiated by developing online training curricula since September 2020. It is planned to be finalized together with a professional organization and training centre in December 2020. Virtual workshop, dissemination and

evaluation meetings have been conducted to continue updating health worker knowledge on immunization. MOH and partners have developed technical guidance and IEC materials, such as defaulter tracking tool and job aids. EPI review in January 2020 recommended to standardize recording and reporting form and analysis of routine immunization not only in public but also private health facilities.

Delivering mobile-based remote training to build capacity and support the selected health workers and community volunteers through pre-recorded voice calls (IVR) to the simple mobile phone or smartphones that health workers already have and use. Most health workers in targeted provinces (Papua and West Papua Provinces) do not have access to vital health information due to limited internet access and cannot take part in any training session or webinar due to physical distancing measures and lack of proper internet bandwidth.

Communication and community engagement

A targeted extensive promotion of catch up immunization (e.g. mass media, social media, sms, posters) will be designed involving cross program and cross sectoral. Engage local community and religious leaders, NGO and other partners to increase demand and counter misinformation using virtual or limited offline strategy are recommended to all provinces. Designated Immunization local champions are expected to create demand on immunization.

- *Equity approach: What are the plans to ensure that underserved and missed communities, including zero-dose children, are prioritised within the country's recovery plan?*
 - *Does the plan consider any additional cohort of children or any new communities that might have missed immunisation due to COVID-19 and have strategies to address them?*
 - *Does the plan consider disproportionate impacts of the pandemic on women and girls or other vulnerable groups (including migrant, disabled, HIV+, LGBTQI communities) and propose gender responsive/transformational strategies to mitigate them?¹⁵*
 - *Does the plan consider new or strengthened partnerships to reach underserved communities, including CSOs, other UN partners, Private Sector Partners (Facebook)?*
 - *What are the gaps in immunisation data and information that will limit the ability to identify missed children, track reaching those children, and monitor the effect of recovery strategies/service delivery mechanisms?*
 - *Does the recovery plan include activities to improve known gaps in immunisation data?*

Leveraging social media to address immunity gaps during Covid-19 through partnership with Facebook. With nearly 140 million Facebook users in Indonesia, the platform has the potential to support the dissemination of key messages targeting users and responding to concerns across multiple levels.

Service delivery strategies

Expanding service delivery to private health facilities is planned. Finalization of public private mix immunization service guidance is under development. This will be followed by preparation of health worker capacity in safety injection, waste management, cold chain management, recording and reporting. Strengthening Sustainable Outreach Services (SOS) for remote areas is continued and will be aligned with other essential health services. Microplan is essential to reach all the children.

¹⁵ Gavi's revised gender policy was launched on July 1, 2020 and can be downloaded here <https://www.gavi.org/programmes-impact/programmatic-policies/gender-policy>

Partner collaboration

Continuing collaboration with professional organizations, WHO, UNICEF, CDC, GAVI, Rotary, CHAI, UNDP and other immunization partners remain essential. Support will be provided in planning, advocacy, human resource surge, technical and financial assistance, capacity building, monitoring and evaluation.

- *Immunisation financing: Has sufficient funding been secured to ensure availability of vaccines, including the co-financing portion, and to enable continuous immunisation service delivery going forward? Please give a brief overview of the funding landscape for the immunisation program¹⁶ and highlight any gaps in support. Describe efforts underway to close any financing gaps.*

Throughout the period of Gavi support to the Government of Indonesia (GoI) for immunization, the GoI notably increased domestic financing for immunization from IDR 143 billion in 2013 to IDR 2,2 trillion in 2018. A significant proportion of this funding was attributed to new vaccine introductions (32%). An analysis of trends in total immunization funding over the past 5 years shows that the central government budget increased annually, emerging as the dominant source of funding - on average 85% of total immunization funding. As the central budget increased, GAVI's share of funding significantly decreased from 18,5% of total immunization funding in 2014 to 8,9% in 2018. This is indicative of the GoI's continued commitment to invest in the strengthening of immunization service delivery in Indonesia.

The EPI relies on various sources of funding at the national and subnational levels to conduct critical immunization activities. At the national level, central government budget and external assistance (donor) comprise the two main funding sources. At the subnational level, local government budgets cannot solely support the program, and as such transferred funds from central budget are likely to be the main funding source for the program. Additional funding sources in the private sector include health insurance and out-of-pocket payments.

The *Minister of Health Decree No. 12 of 2017* established a distinct role between central and subnational governments, in which the provision of vaccines, cold chain equipment and other related immunization logistics should be provided by central government; while local government should be responsible for all program operational costs. As a result, a significantly larger proportion of the immunization budget would be allocated to the central government compared to local governments. In terms of funding utilization, vaccine procurement has constituted the largest share of spend within the immunization program, comprising 77% of total immunization spend over the past 5 year period, for which the total Gavi contribution for the period accounted for 15%.

Based on the latest cMYP for the immunization program for the period 2020-2024, it is estimated that there will be a 17% funding gap (based on secured funding only) in future resource requirements for the program. Over the next 5 years (2020-2024), EPI plans to expand PCV roll-out to additional provinces in the short-to-medium term reaching nationwide coverage by 2024. In addition, EPI plans to expand coverage of HPV and JE to additional provinces in the current 5 year program cycle, as well as to introduce Rotavirus vaccine in 2023 and expand coverage thereafter. Considering the highly decentralized health system, the role of subnational governments in addressing local funding gaps is critical for the immunization program post-Gavi support in upcoming years. Based on CHAI's analysis at the subnational level, 11 out of 34 provinces in Indonesia indicated a medium to high-level of dependence on Gavi funds for

¹⁶ Including sources of funding.

immunization activities (see *Figure 1*). Furthermore, regardless of varying provincial fiscal capacity, Gavi's share of funding for the period 2016 to 2018 ranged from averages of 30% up to 50% of total health funds for provincial immunization programs. This funding was spent mainly (80%) on new vaccine introduction activities, e.g. advocacy, campaigns, capacity building of health workers, and other program management activities e.g. M&E.

With the prioritization and scale up of new vaccine introductions to ensure coverage in Indonesia for all critical antigens, PHOs require greater budget allocations to support successful implementation for the immunization program. With Indonesia transitioning out of Gavi, PHOs & DHOs need to understand the implications and potential gaps for their immunization funding. To ensure future sustainability of EPI at both the national and subnational levels (particularly at provincial level), potential strategies that EPIs may consider include the mapping of expected funding gaps, identification of potential resources coupled with strong advocacy strategies to close funding gaps and secure adequate budget for immunization programs. Potential resource mobilization strategies that have been identified through CHAI's budget tracking exercise include budget tagging, drawing from village funds and capitation funds, and targeted partner support. Furthermore, the strengthening of provincial and district staff capacity to conduct strategic planning and budgeting aligned with the national cMYP should be prioritized to optimize existing funding and mobilize additional resources to meet program targets going forward.

Roadmap for further short/medium/long-term planning

The roadmap for long term planning was updating Comprehensive Multi Year Plan National Immunization Program Indonesia (cMYP) 2020 – 2024 to supplement immunization strategy during COVID-19 pandemic is ongoing, including identification of financial gaps for technical assistance, service delivery, monitoring and others. Currently, lack of PPE for health workers providing immunization service has been reported from subnational governments. Advocacy to local and national governments to address this issue has been conducted.

- *Have you been able to mobilise funding or the strategies described above to restore and strengthen routine immunisation?*

In response to the disruption to immunization service delivery due to COVID-19, the EPI and partners developed technical guidelines for immunization service delivery during the COVID-19 pandemic to support healthcare workers to continue immunization services and minimize further disruptions. The technical guidelines provide details on requirements and standard equipment for healthcare workers in providing immunization services to populations, including catch up strategies. The guidelines were disseminated and socialized nationally through a series of virtual meetings between national and subnational EPIs. It is expected that catch up activities will continue to be implemented and be accelerated in the remainder of Q4 2020 and going into Q1 2021, particularly once a COVID-19 vaccine is introduced and disseminated to healthcare workers.

CHAI will continue to revise the integrated costing tool aimed at supporting subnational governments to develop comprehensive immunization program plans and budgets, contributing to the restoration of immunization service delivery and coverage.

- *How is financial support from other donors reaching the immunisation programme?*

Since PCV introduction in October 2017 and for plans to expand PCV coverage into additional provinces initially and nationwide in the longer term, CHAI will continue support PCV expansion across 11 provinces (NTB, Babel, West Java, East Java, Banten, Central Java, DIY, South Sumatera, Lampung, East Kalimantan, North Sulawesi).

- *What are the remaining funding gaps in terms of technical assistance, implementation, etc.?*

Based on cMYP 2020-2024, analysis on funding gap with secured funds only showed that the existing gap for the next 5 year (2020 – 2024) showed the existing gap approximately US\$96 million. This funding gap will affect some of the major components of the immunization system such as 'activities and other recurrent costs', logistics (vehicles, cold-chain, and other equipment), and 'SIAs'. 'Activities and other recurrent costs' funding gap implies insufficient funding projected for disease surveillance, IEC/Social Mobilization, short-term training and program management activities. The funding gap (with secured funds only) for 'logistics' suggests that if the government is unable to raise additional funding then it might put under the risk of NVI scaling up plans across the country. SIA related funding gap for this category suggests that if the probable funds and additional financing was not secured by EPI Indonesia then it may risk the achievement related MR & JE campaign during the cMYP period.

- *How will you monitor the recovery of routine immunisation coverage? Is another assessment planned on the COVID-19 impact on immunisation services?*

In order to monitor implementation and recovery of RI, EPI with partners will conduct regular monitoring of routine and catch up immunization coverage, providing feedback to subnational governments and monitoring COVID-19 impact through dashboard EPI and VPD surveillance. A risk assessment will be conducted in Q1 2021 and catch up immunization for all antigens will be planned in selected high risk areas i.e. provinces and districts. Catch up immunization plan guidance is being developed. Microplans will be developed in all levels to reach all the communities. The plan to expand New vaccine introduction is still on schedule and includes HPV, JE and PVC introduction, in line with the cMYP 2020-2024. We anticipate a risk of delay in procurement of these NVIs.

On the impact on financing, CHAI will continue to develop and conduct a detailed COVID-19 budget impact assessment on immunization. This will build upon the initial rapid assessment that was conducted at provincial level on September 2020 as part of the development of an integrated costing tool to inform effective resource mobilization for the immunization program.

- *What was the process and participation in developing this national roadmap?*

Each partner played a specific role in support of immunization planning for the current strategic period, CHAI's focus for support was on PCV expansion as well as routine vaccine coverage, including subnational budgeting and planning, and improving healthcare worker capacity and capability.