

Global Vaccine Action Plan

Secretariat Annual Report 2016

Priority Country report on progress towards GVAP-RVAP goals

INDONESIA

A. Progress towards achievement of GVAP goals

1. Summary

This summary table describes the current situation in Indonesia regarding achieving the GVAP goals. Data used to assess progress towards achievement of GVAP goals can be found in the annex.

Area	Indicator	Indonesia
9. NITAG	NITAG established?	Yes

2. Country ownership of the immunization program

2.1 Immunization policy decision-making capacity

There is strong country ownership of and commitment to immunization in Indonesia, which has its own vaccine production capacity at Bio Farma – a major producer of WHO pre-qualified vaccines for UNICEF and GAVI – a fully-functioning national regulatory authority, a strong vaccine storage and transport system, and supportive government policies.

The country has had a NITAG – the Indonesia Technical Advisory Group for Immunization (ITAGI) since 2007. The committee consists of 18 core members who are experts in a range of fields (paediatrics, public health, infectious diseases, epidemiology, immunology, etc.) and who serve for three years (with the possible renewal for an additional three years). There are additional *ex-officio* and liaison members from other agencies (e.g., the NRA). ITAGI has received assistance from the SIVAC project and WHO to strengthen its decision-making skills based on a technical review of evidence. It is fully-functional, as defined by WHO, and meets at least four times a year (and seven times in 2015).

ITAGI's main role has been to make recommendations to the MOH about the introduction of new vaccines. For each specific vaccine under consideration, a working group is formed to weigh the evidence and conduct or commission specific studies. Studies requested by the

ITAGI and reviewed by the working groups on the impact and cost-effectiveness of JE vaccination in high-risk areas (e.g., Bali) and on the cost effectiveness of introducing measles-rubella (MR) vaccine to control rubella were instrumental to the Government's decision to apply to GAVI for support for targeted JE campaigns and for nation-wide MR campaigns (to be followed by their introduction into the routine program).¹ The ITAGI has recently expanded its role to include monitoring of the national immunization program's progress and to address programmatic issues. In 2013, it recommended changes to the childhood immunization schedule to add a booster dose of DTP at 18 months and a second measles vaccine dose at 24 months. The committee also serves as a trusted, credible voice to the public when issues about vaccine safety arise. For instance, the group communicated with the public following a scandal involving counterfeit vaccines to maintain the population's confidence in vaccination.

2.3 Human resources situation and its impact on the immunization program

Indonesia benefits from a relatively large workforce of health professionals. Most health workers who administer vaccinations are midwives, many working from outreach health posts called *posyandus*). Immunizations are also provided by nurses, doctors and other health workers at health centers (*puskesmas*) and hospitals. Each *puskesmas* has an EPI coordinator, though their skills and training in immunization may be limited. At the provincial and district levels, there are typically two health officers dedicated to immunization – one responsible for program management and the other for cold chain, vaccine, and logistics management.² The number of these positions is inadequate in many places and often not proportional to the size of the population in their area. In recognition of the lack of immunization personnel at the sub-national level, new positions – called supervisor assistants or *wasor* – were created in the past ten or so years in low-performing districts to supplement the immunization staff, with funding from the GAVI HSS grant and from local governments. In 2013, there were more than 200 *wasors* operating in 184 of the country's 511 districts across 25 of the country's 33 provinces.³ According to one informant, these positions are likely to continue with local government funding after GAVI support ends because their value has been well demonstrated.

According to several assessments, a major human resources problem affecting the immunization program at the district and village level is the high turnover rate – often every 3-6 months – among EPI coordinators and managers, nurses, midwives, and cold chain technicians and other health workers.⁴ This reduces the development of expertise in immunization and commitment to immunization activities, and requires frequent staff training on the topic. In 2013 alone, more than 111,000 health personnel received training in routine

¹ In the case of JE, the vaccine will be introduced only in high-risk areas.

² Government of Indonesia. Comprehensive multi-year plan for the national immunization program, 2015-2019.

³ Government of Indonesia. Comprehensive multi-year plan for the national immunization program, 2015-2019.

⁴ World Bank Group. Issues affecting sustainability of the immunization program in Indonesia. Presentation February 18, 2016.

immunization.⁵ A joint EPI and VPD surveillance review conducted in 2013 also found little or no supportive supervision occurring at below the district level.⁶

At the central Ministry of Health level, there are 20 full-time positions in the national immunization program (NIP), as well as several staff on contract for special assignments (e.g., ITAGI secretariat, AEFI monitoring). However, at the time of the EPI/surveillance review, only 14 of the permanent positions were filled. Some of these positions are supported financially by WHO, and this assistance will end in December, along with most GAVI support. The central immunization program team also experiences a high level of turnover; most there at present are relatively new and not specialists in immunization. They have recently received mid-level management (MLM) training in immunization with GAVI and WHO support. The team members make supervisory visits to the provinces on average 2-3 times a year. Their influence to affect change and to advocate for increased immunization funding and activities at the local level is, however, somewhat limited by their relatively small number, lack of skills in advocacy, relatively junior status and newness to the field of immunization, and by the decentralized government structure.

B. Partner support to address major challenges to meet the GVAP goals and targets

While financial support from partners for the immunization program makes up a relatively small portion of immunization financing in Indonesia, partners have provided important technical support and expertise to the Government in specific areas for several years. Critical support has included assistance in developing the surveillance system for AFP/polio and other vaccine-preventable diseases, including laboratory support; strengthening capacity of the country's national regulatory authority (POM); and assistance in designing and implementing studies and assessments to guide the immunization program and measure the impact and value of vaccination. These include coverage surveys, studies of cost-effectiveness, among many others. With financial support from GAVI, partners have also assisted in the introduction of pentavalent and IPV vaccines.

Though the GAVI HSS grant, partners have helped improve the immunization program's performance by: 1) assisting with special efforts to improve immunization coverage; 2) improving the quality of immunization data and local capacity in data collection, reporting and analysis; and 3) improving health worker skills and knowledge in immunization by developing teaching materials on immunization and MCH service delivery for midwifery training institutes. Two initiatives to note that are supported by partners with GAVI HSS financing in the aim of addressing the country's lagging immunization coverage rates are:

- The **Drop-Out Follow-Up (DOFU) strategy** being implemented in 60 districts in 18 provinces,
- The **Sustained Outreach Service (SOS) strategy** to improve the delivery of immunization and other MCH services to remote, sparsely-populated islands in three provinces (E. Nusa Tenggara, Maluku and N. Maluku). This strategy, supported by UNICEF and WHO, involves outreach visits to these communities (at least 3-4 times a year) to provide children and women with integrated MCH services. Local

⁵ cMYP.

⁶ World Health Organization. Joint national and international EPI and VPD surveillance review, Indonesia, 2014.

governments have recognized the benefits of this strategy and have started to contribute to its implementation.

Much of the funding for technical support from partners, including WHO and UNICEF, will end when regular GAVI support, including the HSS grant, concludes in December 2016. However, it will be critical that partners continue to provide technical assistance to both the central government and sub-national governments with such activities as VPD surveillance, new vaccine introductions (e.g., JE, PCV, HPV), impact assessments, and other advocacy efforts to justify investments in immunization. Technical assistance from partners will help ensure that the gains made with past support, including polio eradication and progress towards measles elimination, can be sustained and reach their full potential.

ANNEXES

Planning and management:

- Stockout of vaccines: no events in 2015.
 - cMYP: 2015-2019
 - Annual Plan: Yes
- Country decision making: NITAG meeting the 6 minimum criteria defined by WHO for a functioning NITAG