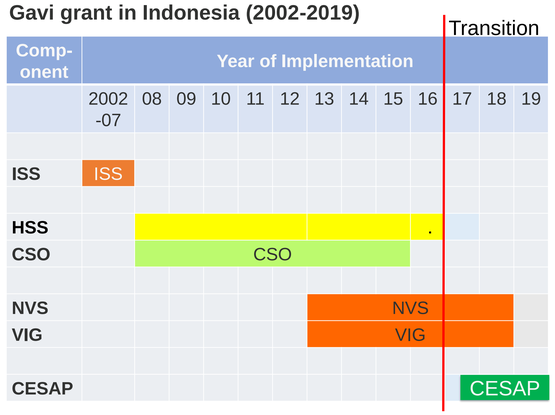
Indonesia

Managing the Transition from Gavi Assistance

Jane Soepardi, Wahyu Utomo, Ardhiantie, Risca Ardhyaningtyas

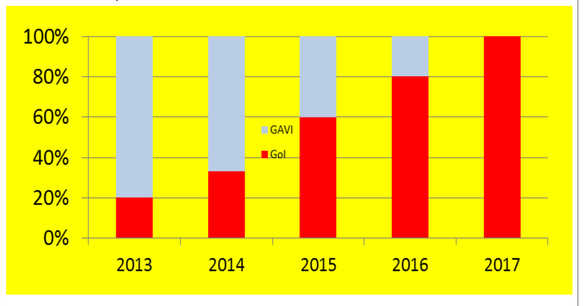
1. Background Information

Gavi grant in Indonesia (2002-2019)



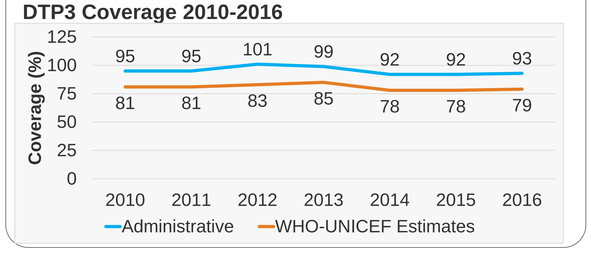
- In 2016, Indonesia was in the last year of the accelerated transition phase (entered in 2012) and fully self-financing pentavalent vaccine since 2017.
- Gavi transition mission in July 2016 decided to allow for no cost extension of HSS until July 2017, However IPV and HPV co financing until 2018 .
- Indonesia does not receive graduation grant, but the remaining funds coming from component grant of NVS & VIG Pentavalent and HSS could be used for activities to support the activities in the transition phase. This activities under new component so called CESAP is now in the process of approval.

Government Co-financing in Pentavalent Introduction Indonesia, 2013-2017



New and planned vaccine introductions with Gavi support: Penta, IPV, HPV, MR, and JE vaccine,.

DTP3 Coverage 2010-2016



2. Financing

Total Expenditure of EPI Vaccine 2015-2017 & Projected Cost 2018-2020 (USD millions)

Source	2015	2016	2017	2018	2019	2020
MoH	37.8	47.6	84.3	145.1	123.8	212.6
Gavi	7.9	8.1	33.6	14.2	0	0
Total	45.7	55.7	117.9	159.3	123.8	212.6

Challenges and how they are addressed:

- **Priority are competitive**, many health programs are priority. Advocacy to the key stakeholders and Improving the quality of plan including better projected cost estimation would help to convince the decision makers.
- **High price of new vaccines** (especially for import vaccines). Aside from continuous advocacy to the key stakeholders at the national and sub national level, an opportunity to procure imported vaccines through UNICEF - which is much cheaper than commercial rate - is being explored.
- The availability of **operational budget** in some regions. Implementation of advocacy and socialization on the cost of investment in immunization program has been regularly conducted by central level.
- In Indonesia's decentralized context, system of intergovernmental transfers is complex and fragmented, some earmarked for inputs; district governments have discretion over how budgets are allocated, which leads to wide variations in local health spending. Indonesia does not have an explicit result-based orientation in its system of intergovernmental fiscal transfers.

3. Procurement

- The Central government is responsible for procuring vaccines and other immunization logistics. National policy for vaccine and other logistics procurement is in place under the Pharmaceutical unit of Ministry of Health. The mode of procurement for vaccine follows existing government regulation covering e-purchasing and open bidding including direct procurement.
- Currently, intensive discussions in the Ministry of Health on the possibility of procuring vaccine through UNICEF (prioritized to the imported vaccines only, so that it would not disrupt the procurement of locally produce vaccines).
- The domestic vaccines have been produced by Biofarma - a National Vaccine Manufacturer. All traditional or routine vaccine including pentavalent produced by Biofarma. Biofarma also:
  - Imports and distributes new vaccines such as MR, HPV and JE.
  - Supports cold chain logistics function for EPI vaccine
  - Notifies government of anticipated supply issues
- Whenever Biofarma has capabilities to produce their own new vaccine, we will surely get more affordable price for new vaccine, as experienced with pentavalent vaccine.

4. NITAG

- The National Immunization Technical Advisory Group (NITAG) in Indonesia is officially recognized as "The Indonesian Technical Advisory Group on Immunization" (ITAGI) - was established in 2007 by Minister of Health Decree.
- It has formal terms of reference and conflict of interest policy
- Represented expertise include Pediatric, Public Health, Infectious Diseases, Epidemiology, Immunology
- The ITAGI has four internal meetings annually which occur over 2 days. Email correspondence occurs regularly. Meetings are not open to public. Experts, including representatives from vaccine manufacturers, may be invited to make presentations as needed.

5. Coverage and Equity

Challenges:

- Low coverage in difficult-to-access or remote locations
- Social barriers such as poor, migrant, and mobile population
- From supply side, capacity of health workers and high turnover of human resources

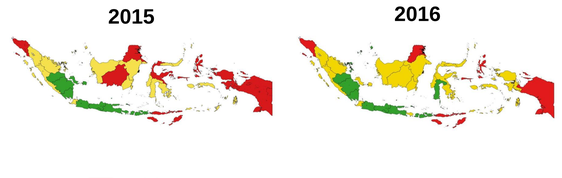
Coverage Disparities:

- Based on RISKESDAS 2013, no disparity in coverage between male (59.0%) and female children (59.4%).
- Children in the urban areas has high coverage (64.5%) as compared to rural areas (53.7%).
- Some regional disparities, especially between Java and non Java areas.

Strategies:

- Advocacy to gain political commitment from authorities to support immunization, i.e. develop regulation that immunization is mandatory.
- Implement/create micro planning in districts and health center level
- Supply side:
  - Address high operational cost in remote areas by piloting Sustained Outreach Service (SOS) strategy that integrates service delivery, with minimum package of immunization and vitamin A supplementation
  - Address high risk communities in urban slum areas by piloting Reaching Every Community (REC) project in DKI Jakarta province.
- Improve demand creation:
  - Disseminate immunization communication strategy among health care workers, train health personnel in personal communication, and empower the community in immunization activities
  - Continue raising awareness among caregivers on the benefit of immunization.
  - Improve communications and advocacy initiatives for individuals, families, and communities designed to increase understanding of the value of immunization and counteract growing anti-vaccination groups and negative campaign on immunization.

DTP3 Coverage by Province



6. Transition Plan

- Evidence-based country immunization policy and strategy should be formulated through the consultation of experts and review of immunization related legal and policy framework.
- Local research study along with NRA labs needs to be undertaken to show the sterility and safety of multi-dose open vial policy for vaccine (MDVVP). This will result in a policy change for use of vaccine in field and minimize the missed opportunities.
- NIP faces challenges that include managerial, systems, socio-behavioural, financial, and communications bottlenecks. A number of operational research have been proposed to be conducted during the transition phase. The implementation of this activity will be conducted by WHO, Unicef and World Bank in collaboration with EPI Unit of the Ministry of Health.

7. Key Lessons

The strength of Indonesian immunization program in improving coverage among others that could be used as lesson learnt, are as follows:

- Immunization through Community Based Integrated Heath Post (Posyandu)
- School Based Immunization
- Strong partnership in the program implementation among government and non-government organizations
  - Religious based organizations and community leaders promote immunization at grass root level
  - Prominent professional organization includes pediatricians, medical, midwives, nurses associations, etc socialize scientific information regarding vaccine and immunization.

Gavi The Vaccine Alliance

LNCT Learning Network for Countries in Transition

Bill & Melinda Gates foundation