Restoring RI Coverage in the Wake of COVID-19

**Drivers:**
- Disruption to service availability, both outreach sessions (>90%) and fixed services in PHC (65%), due to COVID-19 related service closure.
- Public fear of COVID-19 caused caregivers avoid bringing their children to health facilities, especially public HF.
- Misinformation on immunisation grew rampant.

**Explaining Factors:**
- High COVID cases lead to strict limitation to social gathering, including health outreach sessions. It also caused HCW’s shortage due to COVID-19 related illness.
- Symptomatic COVID-19 cases are seeking treatment in HF’s that led people to limit or avoid visiting areas with probable high COVID-19 cases.
- COVID-19 vaccination brought focus on immunisation that led to people questioning vaccine safety, AEFI, and halal/haram issues. Misinformation related to these are spread through WAGs, which some believe in.

**Current Initiatives:**
- Developed, disseminated and implemented technical guidelines of immunisation services during pandemic.
- In addition to above technical guidelines, also strict implementation of health protocol, including PPE distribution.
- Developed and disseminated IEC materials through various methods.
- Strategic involvement of religious leaders to increase vaccine acceptance.

**Possible Solutions:**
- High level commitment from MOHA to subnational leaders for immunisation program prioritisation.
- Immunisation schedule by appointment
- Improve private health facilities capacity
- Strengthening collaboration and cooperation with Ministry of Information to reduce hoax at digital media.

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**Workforce (National):** 32

**Workforce (Sub-national):** 102 at 38 Provinces

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**Key Measures 2018 – 2021**

| Number of Children under 1 year of age (mio) | 18 | 19 | 20 | 21 |
| Coverage with third dose of DTP vaccine (%) | 4.7 | 4.6 | 4.6 | 4.4 |
| Coverage with the first DTP dose under 12 m. (%) | 85 | 85 | 77 | 80 |
| Drop-out rate between the first and third dose of DTP vaccine under 12 m. (%) | 90 | 90 | 83 | 88 |
| Coverage with the first DTP dose w/ age restriction (%) | 5 | 5 | 6 | 8 |
| Drop-out rate between the first and third DTP dose w/ age restriction (%) | n/a | n/a | n/a | n/a |
| PCV-1 coverage (%) | 58 | 68.3 | 9.6 | 27.6 |
| DPT-1 coverage by 4 months (%) | n/a | n/a | n/a | n/a |
| MCV-1 coverage timely (as per schedule) | 92 | 95.1 | 85.2 | 87.3 |
| MCV-2 coverage timely (as per schedule) | 67 | 72.7 | 64.7 | 60.5 |
| Number of Zero dose children by 12 months (k) | 79 | 84 | 469 | 615 |
| Number of Zero dose children by 24 months (k) | 103 | 553 | 1.084 |

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**Drivers:**
- Political commitment from subnational leaders to prioritise immunisation for children.
- Indonesia’s geographic areas: hard-to-reach villages.
- Vaccine stock out (EPI reviews 2020 and PPE new vaccines : PCV, IPV).
- Misinformation and disinformation/hoax related to immunisation within communities.
- New vaccines introduction also translated to higher HCW’s workload and training need.

**Explaining Factors:**
- Lack of strong direction from MOHA that followed by reward and punishment system.
- Hard-to-reach areas need specific strategy that differ from other areas, and usually need high operational cost.
- Delay vaccine procurement especially for import new vaccine.
- Delay vaccine distribution due to travel restrictions during COVID-19 pandemic.
- Antivax campaign, halal-haram issues, and low literacy in some areas.
- Operational cost to support HCW higher workload (additional staff or incentives), and training cost that need to be budgeted by subnational level.

**Current Initiatives:**
- Immunisation program as part of standard health services (SPPM).
- Revision the National Planning Strategy (Rencana).
- Nusantara sehat program (HVs placement in hard to reach area for health program including immunisation), regular flying doctor to hard to reach area integrated with MCH.
- Improve cold chain equipment.
- Adoption Electronic Immunization Registries (EIRs): know locally ASIK for routine immunisation.
- Research and development domestic vaccines to meet the NIP (14 antigens) including transfer technology acceleration.
- Scale up of Human Centred Design (HCD) approach.
- Establish communication forum group for immunisation involving media and journalism.
- MNCHs Interrupt to term temporary placement outcome include immunisation program activities.

**Possible Solutions:**
- Additional health operational cost (BOK) based on performance.
- Remote training with e module and e certificate.
- Adoption Electronic Immunization Registries (EIRs): know locally ASIK for routine immunisation.
- Research and development domestic vaccines to meet the NIP (14 antigens) including transfer technology acceleration.
- Scale up of Human Centred Design (HCD) approach.
- Establish communication forum group for immunisation involving media and journalism.
- MNCHs Interrupt to term temporary placement outcome include immunisation program activities.