Unravelling the Cost of Reaching the Unimmunized Children to Inform Financing Reforms in Indonesia

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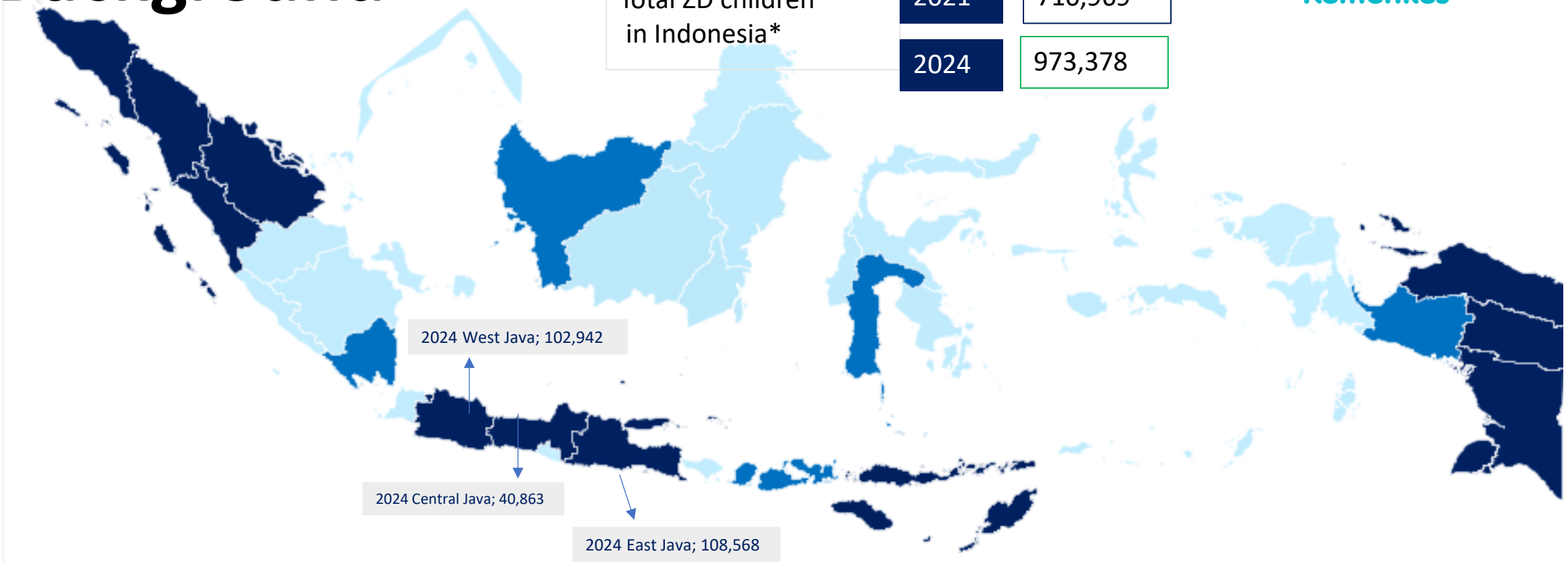
Background

Total ZD children in Indonesia*	
2021	710,969
2024	973,378



*) Data Source: MOH administrative data

In 2024, **West Java, Central Java, and East Java** collectively accounted for **more than 25% of zero-dose** children in Indonesia.

Objectives

Validate **Zero** Dose children **at PHC** level

- Identify children who haven't received DTP-1
- Triangulate number of zero dose children by utilizing health facility data across program (MCH, Nutrition, Health Promotion) at PHC level

Data-driven activity planning, costing, and budgeting for ZD intervention

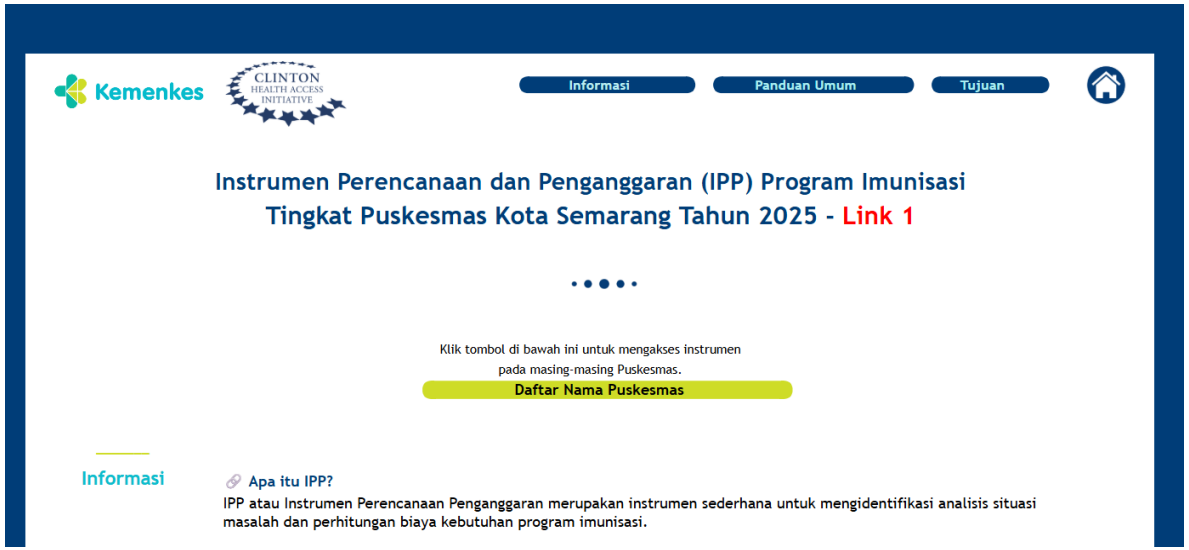
- **Conduct situational analysis**, identify key bottlenecks
- Calculate the bottom up costing approach for operational cost
- **Prioritize interventions to be integrated into PHC annual work plans**

Mapping and mobilizing resources and identifying funding gap

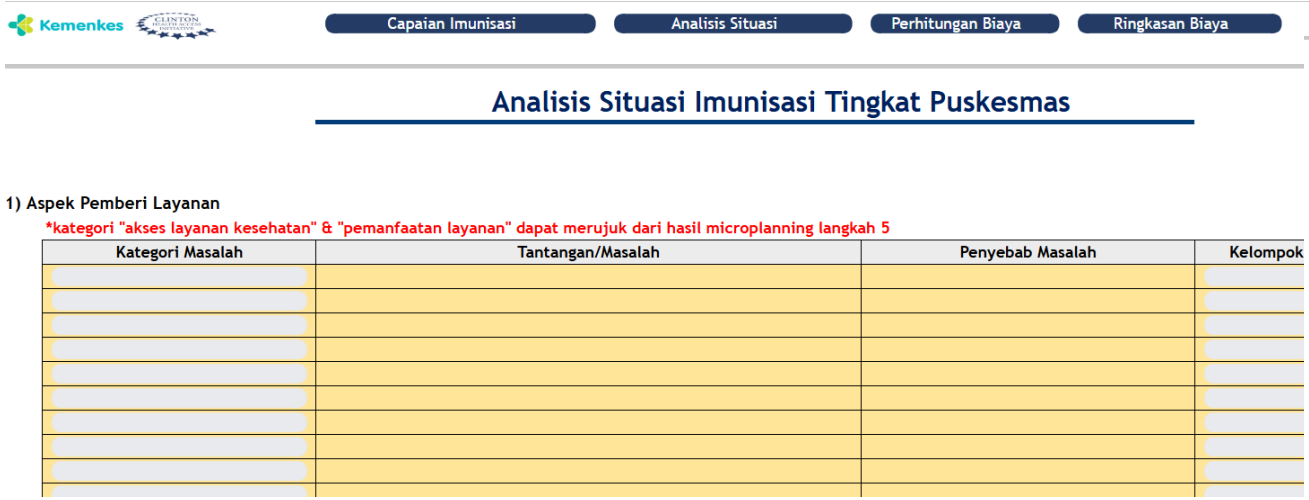
- Mobilize funding resources for each planned activity across PHCs
- Assess alignment of funding with planned ZD reduction activities
- Identify funding gaps & advocate for potential other source

Findings have **catalyzed budget dialogue and financing reform** cross-program and cross-sector commitment in district level to optimize resource allocation, improve immunization equity, and strengthen zero-dose reduction strategies within Indonesia’s decentralized health system.

Methods



- This ongoing research uses an adapted WHO cMYP framework to develop immunization cost plans from **295 PHCs across 12 districts**, using **a bottom-up costing approach** that excludes vaccine procurement, disposable medical supplies (which are centrally funded and distributed), and health personnel costs.
- Data were collected through a series of workshops and stakeholder discussions conducted from **November 2024 to May 2025**. A spreadsheet-based tool was used, completed by each PHC and **monitored by the Provincial and District Health Offices.**



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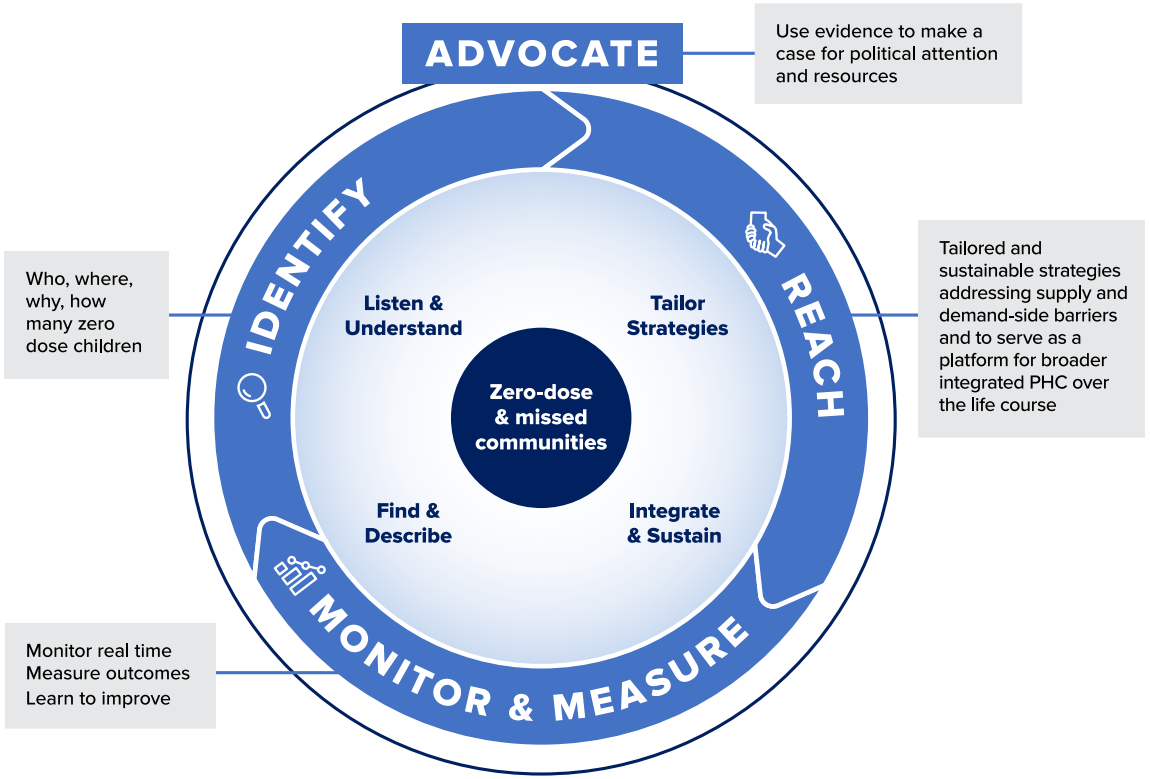
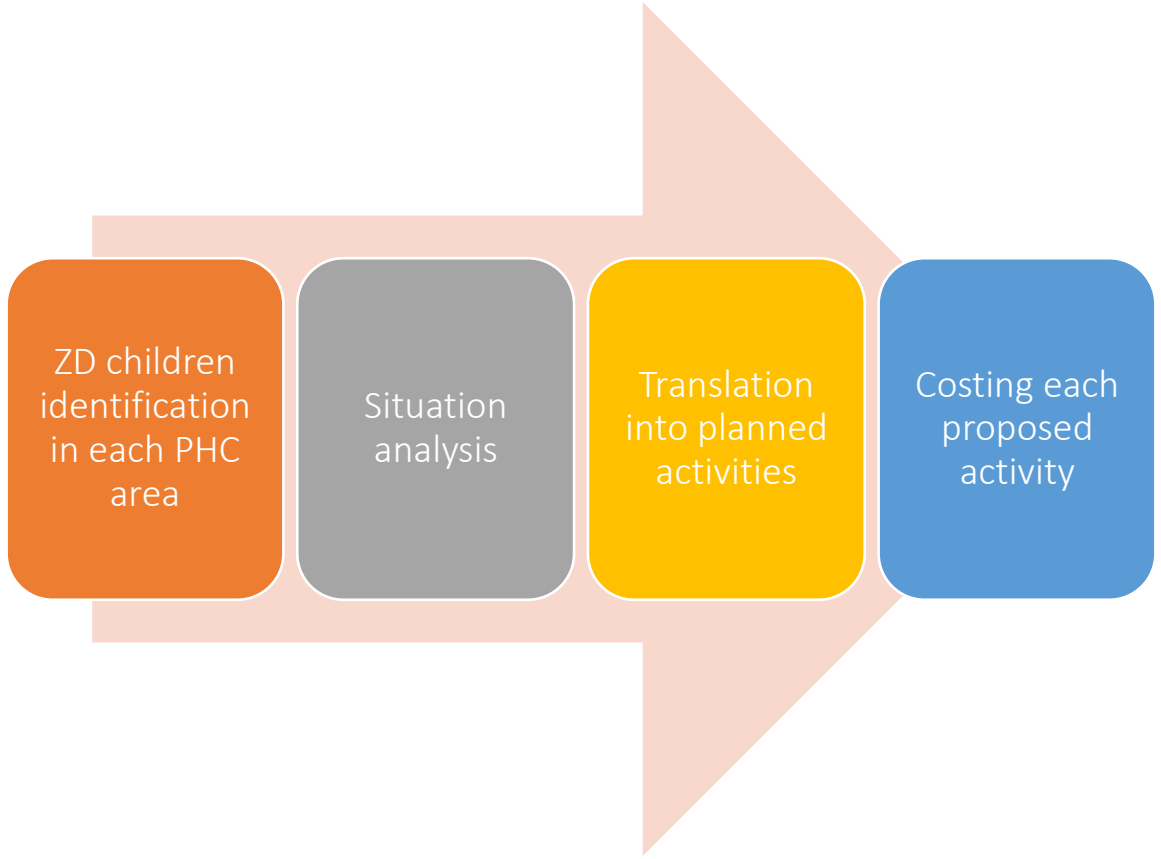
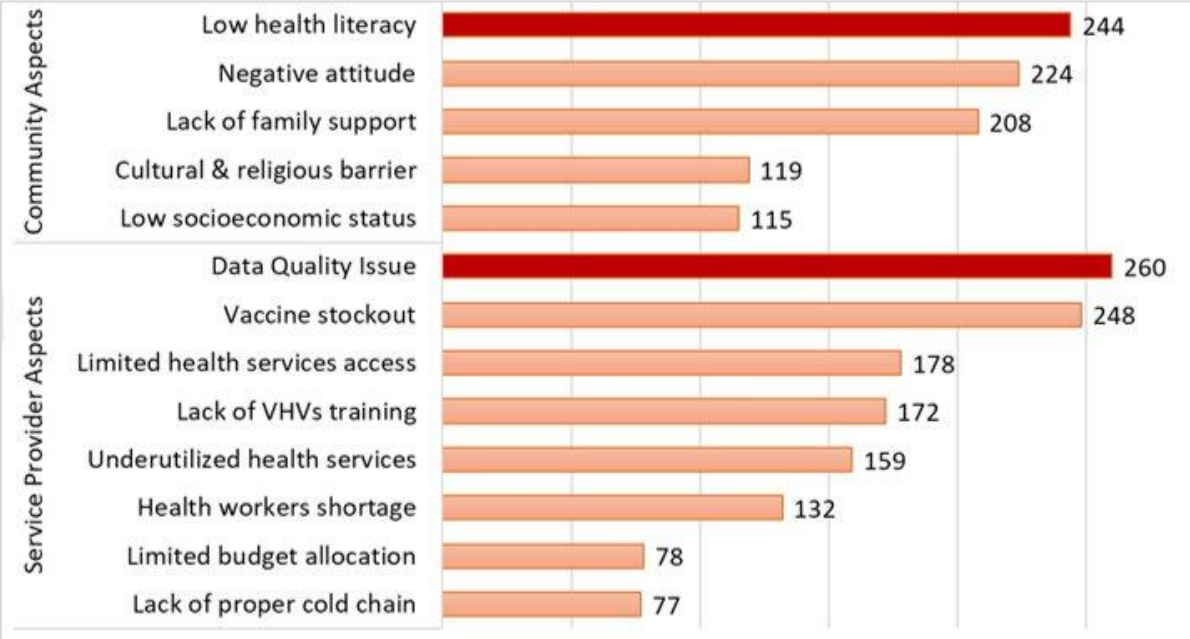
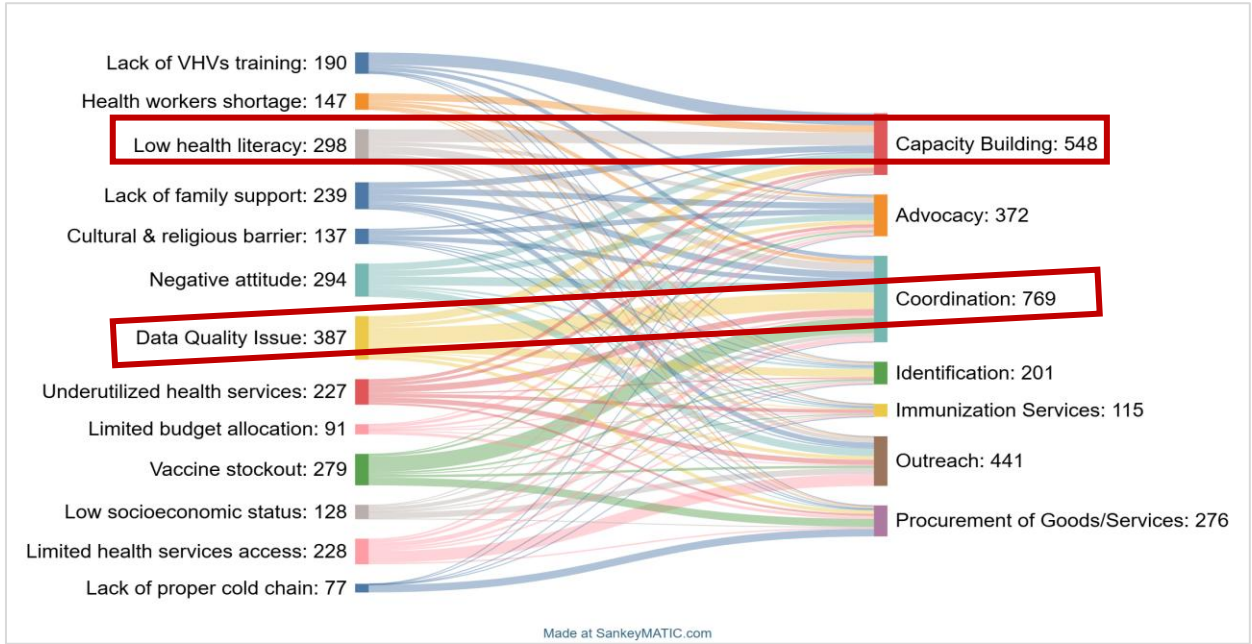




To guide structured analysis in PHC level, we use the six WHO health system building blocks to categorize the situation analysis, while strategies to reach zero dose are categorized using the IRMMA framework.

Result: Situation Analysis





Our situation analysis indicates that the main challenges in reaching zero-dose children is poor data quality (260 out of 295), hence as PHCs could not work independently, they need to coordinate cross program and cross sector. On community side, the challenge includes low health literacy (244 out of 295). To address these issues, targeted capacity building are essential.

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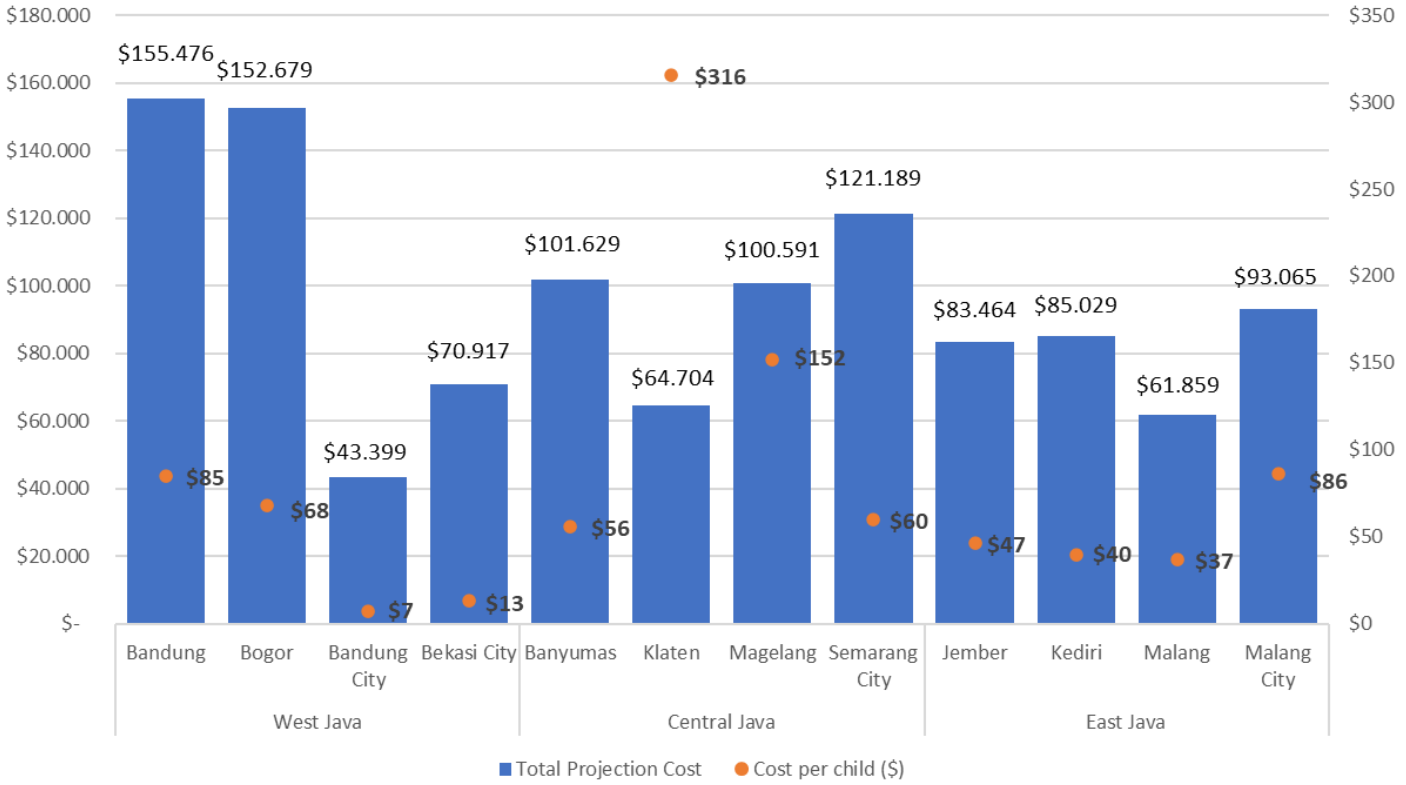
Total projection cost and cost per child (USD)

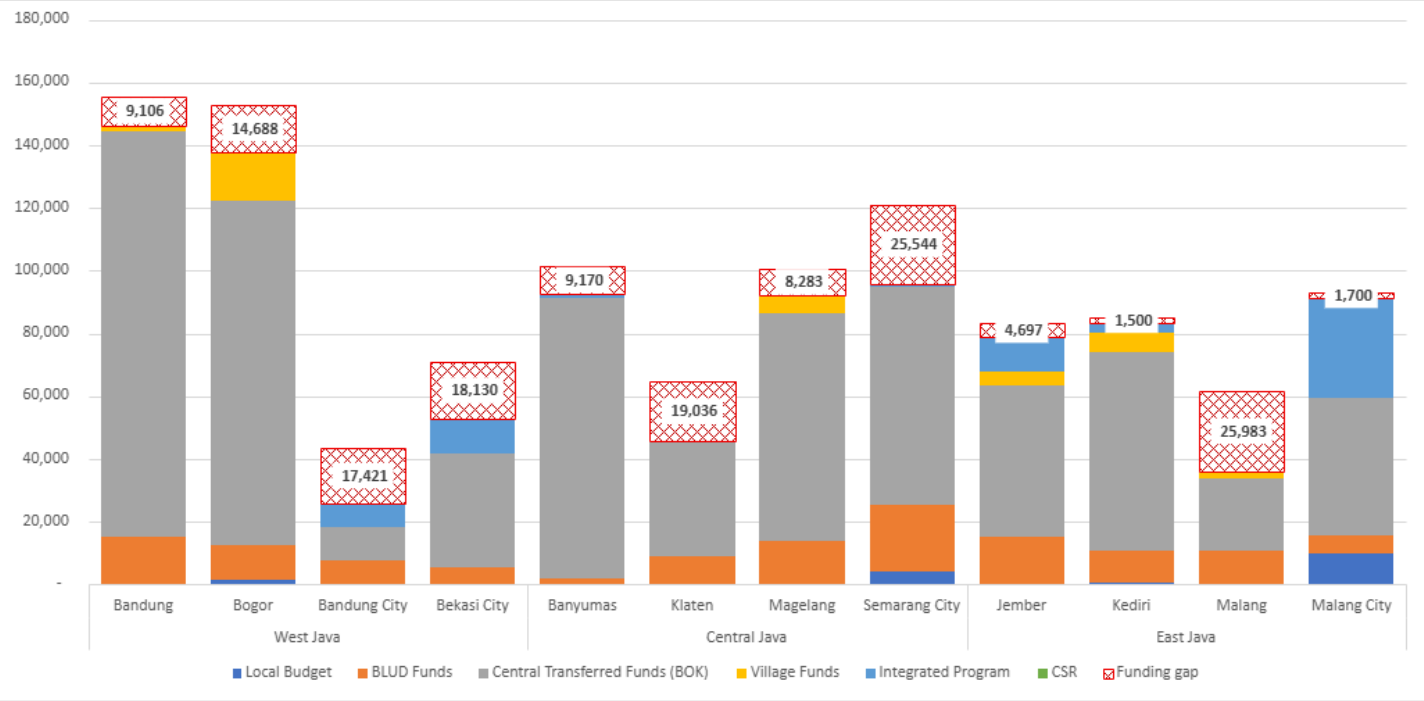


Highlights:

1. Significant variation in financing policies across districts—such as local transport costs, incentives for community health workers (kader), and other operational expenses.
2. Geographic size and target population scale also influence cost differences.
3. The total projection cost in each district/cities varied from $43,399 (Bandung City) to $155,476 (Bandung District)
4. Reaching zero-dose (ZD) children tends to be more costly in districts than in urban areas.
5. Klaten District recorded the highest cost per ZD child at USD 316, while Bandung City had the lowest at USD 7.
6. Cost to reach in Klaten district is the highest driven by dispersed target population, and reliance on outreach and mobile strategies

Exchange rate:
1 USD = Rp. 16.000

Amount of Funding Source and Gaps



Highlights:

1. Identified challenges: **Inability to distinctively differentiate between zero-dose (ZD)-specific activities and routine immunization (RI)** efforts at the implementation level. Some a integrated within the broader RI delivery system.
2. Despite the **lack of standalone interventions**, many existing RI activities can simultaneously help reach ZD children.
3. Efforts to reach ZD populations are integrated into routine services, but are **constrained by limited resources and human capacity** at the service delivery level.
4. The largest funding gap is identified in Malang district ($25,983) followed by Semarang city ($25,544)
5. In Semarang City, the gap is mostly driven by the need for **community engagement and socialization** activities, while in Malang District, it is largely due to the need for **additional incentives for community health workers.**

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Amount of funding source identified and gaps for each activity category, across 12 districts

	Advocacy	Coordination	Procurement of Goods/Services	Capacity Building	Immunization Services	Outreach	Identification
Funding gaps	$1.517	$35.919	$19.625	$36.441	$16.663	$29.378	$13.330
Funding source identified	$36.075	$211.109	$146.784	$308.330	$153.873	$204.706	$61.045

Highlights:

1. The largest proposal is attributed to the **capacity building strategy** reaching approximately USD 350,000.
2. The most significant funding gap is found in the **capacity building strategy** (USD 36,000), followed by the coordination strategy (USD 36,000) and outreach (USD 29,000)

Exchange rate:
1 USD = Rp. 16.000

Policy implication

1. **Village funds**, which already support community outreach, immunization, Posyandu, and maternal-child health programs, **should be strategically leveraged to strengthen local health systems through capacity-building initiatives.**

   Policymakers should prioritize integrating structured training, skill development, and community empowerment programs within existing village fund frameworks to enhance the effectiveness and sustainability of local health services. This approach would optimize resource utilization while strengthening grassroots healthcare delivery.

2. To accelerate progress toward Zero Dose (ZD) targets, **national budget planning should be realigned to better address subnational priorities**, including **increased and sustained funding for outreach and subnational coordination**—areas that are currently under-resourced. This requires **structured fiscal decentralization, needs-based allocation, and stronger accountability mechanisms** to ensure equitable immunization coverage.

3. In Indonesia's decentralized context, our findings catalyzed local policies initiated by District Health Office (DHO) leadership, encouraging PHC leaders to mobilize available funding sources at the PHC level and to maximize program integration to support activities to reach the zero dose children

Thank you

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