Indonesia

Background Information

Despite major progress in DOTS expansion over the last few years, the Republic of Indonesia still ranks third on the list of TB 'high burden' countries in the world. Its incidence is estimated to be around 540,000 new cases per year. Yearly there are around 240,000 new smear positive cases. The estimated prevalence of TB is around 600,000 smear positive cases and yearly around 100,000 people die of the disease. Indonesia has made rapid progress towards reaching the global targets; case detection rates have steadily increased to from 21% in 2002 to 67% in 2005, while the treatment success rate has remained steadily above the national target of 85%. The quality of DOTS implementation through the Puskesmas (Health Center) network was the cornerstone for further progress towards these targets. The significant increase of external financial resources has challenged the capacity of the NTP and its partners in their efforts to expand the program. Central and provincial program management units are facing an increasing workload due to the expansion of activities. Current challenges to DOTS expansion in Indonesia can be summarized as; equitable access for the un-reached, difference in area-specific TB burden, case management in hospitals, clinics and private practices, emergence of MDR-TB and TB/HIV and the need for public-private partnership. There is still a need to expand and improve access to effective TB treatment and quality care through a variety of channels (public sector providers, private sector and NGO providers, HIV and other programs) while maintaining program quality. Two related issues of extreme importance, TB in the context of HIV infection and MDR-TB, require new or different approaches in addition to DOTS. The purpose of TB CAP is to strengthen local technical and management capacity through external TA, with the objective to improve access and quality of the TB services provided by government as well as non-government health providers. TB CAP partner **KNCV** has been leading the project while collaborating closely with the NTP, international and local partners and external donors, in particular USAID. It will continue the successful work started under TBCTA. **FHI**, **MSH** and **WHO** have been supporting the program as collaborating partners.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	224	227	230
TB incidence (WHO estimates) per 100.000 population	245	239	239
HIV sero-prevalence among TB patients	0.9%	0.8%	2%
Case fatality of HIV positive TB patients (estimated)	1%	1%	n/a

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	96	96	96
Percent of public clinics implementing DOTS strategy (TB CAP areas)	100	96	96
Case detection rate (all cases) (Country total)	48	60	
Case detection rate (all cases) (TB CAP areas)	51	63	
Case detection rate (SS+ cases) (Country total)	66	76	
Case detection rate (SS+ cases) (TB CAP areas)	56	70	
Treatment success rate (new ss+) (Country total)	90*	91**	
Treatment success rate (new ss+) (TB CAP areas)	87*	91**	
Meets MDR TB quality standards defined by TB CAP (max. 3)	**0**	**2**	**2**
• Political will	No	Yes	Yes
• Surveillance (or survey) system is in place	No	No	No
• At least one laboratory in the public sector performing culture & DST	No	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**0**	**2**	**2**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	No	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	No	Yes	Yes
• Coordinating body is in place	No	No	No
• Nationwide reporting system for TB/HIV is in place	No	No	No

* 2004 cohort ** 2005 Cohort (NTP estimates)

3. Financial Overview (US$)						
Period	Funds		Expenditures			Level of Spending
	Obligated	Budget	Declared	Accrued	Total	
Year 2	2,970,000	3,220,000	1,476,677	664,952	2,141,629	67%

4. TB CAP Project Highlights 2006-2007

TB CAP has considerable additional value for the NTP by creating supplementary local technical capacity being linked to specific external expertise.

Considerable progress has been made regarding implementation of ISTC and the establishment of ISTC task forces in four densely populated provinces in Indonesia. Involvement of professional societies in the ISTC activities has added another driving force to DOTS expansion and PPM. These Taskforces will boost PPM expansion and involvement of hospitals in the NTP (HDL). Strong involvement of professional societies seems very promising.

Major accomplishment of TB CAP is the creation of supplementary local technical capacity in various fields, being linked to specific external expertise. Recruitment of 18 new local technical officers has had the most positive impact on accomplishments. The addition of this young professional staff leads to increased Hospital DOTS activities in teaching - and VCT hospitals and boosting DOTS expansion to 10 clusters of districts in Jakarta, West, Central and East Java. Posting of a senior technical officer at the Central KNCV office in Jakarta is relieving the workload of the RO considerably. Recent posting of a Senior Technical Officer in Surabaya will expectedly boost activities in the Eastern parts of Indonesia, and HDL activities in East Java. The increased number of technical staff working all over the country deserves a sound human resource management approach to ensure optimal functioning of the workforce assisting the NTP. The continuous local TA provided through TB CAP , boosted by intermittent external TA has a positive impact on the activities at health facility level, both in the hospital sector as well as in the remote areas of Papua. Situational analysis has been made in both areas which form the basis of the work plans for DOTS expansion in the provinces and districts.

The major challenge was dealing with the impact of GF suspension. This had major implications for implementation of TB CAP activities because most TA activities are depending on operational inputs /work plan supported by GF. The TB CAP work plan/budget needed to be adjusted on a regular base to cope with the GF funding restrictions. This has caused serious delay in implementation of a wide range of activities related to all Intermediate Results. Moreover involvement of RO to support PR and CCM in addressing the conditions for lifting GF restrictions absorbed considerable time and energy of the RO. This had major impact on the already high workload of the RO office, which continued to be understaffed.

Recurrent adjustments of work plan and budget revisions were necessary to cope with the GF funding stop. The purpose is to assure that crucial activities will not be disrupted.

Specific accomplishments in main result areas are as follows;

Increased political commitment; District planning & budgeting tool has been revised for piloting. Staff in 8 districts (5 provinces) has been trained in using the revised tool. Piloting has been completed in 3 rounds.

Strengthened & expanded DOTS

- **Underserved areas/vulnerable groups;** Visits to provinces are taking place and TA has been provided. Three new Technical Officers have been recruited, trained and positioned in IJB and Papua. Currently assessments are being conducted.

- **Improving the quality of DOTS;** A laboratory focal point has been appointed and now coordinating laboratory working group and DRS survey. One new Laboratory Officer recruited and trained.

- **Engaging other providers (PPM);** Technical Officer to provide support to NGOs has been recruited and has started implementing work plan in collaboration with NTP. PPTI assessment conducted, report presented to PPTI and stakeholders, work plan currently in development. Strategic planning workshop with PPTI was conducted in November 2006.

Professional staff recruitment for PPTI has been completed. TA provided to five NGOs (PERDAKI, PPNI, PELKESI, WVI and NU). One technical officer appointed and trained.

- **Strengthen diagnosis & treatment of MDR-TB;** TA delivered by IMVS sub-contractor for planning, monitoring and on-the-job training. TA provided to develop work plan for dissemination of ISTC. National MDR expert group has been established, DOTS plus outline presented to National expert committee. MDR guidelines distributed. MGIT960 installed in Microbiology UI. First cultures revived for DST in Surabaya. Unabridged version of the ISTC was finalized and amended by IDI and a plan for dissemination developed. National IDI Task Force was established. TA for culture, DST and EQ has been delivered by IMVS, recommendations are being followed up.

- **TB in prisons;** Strategic plan for TB in prisons finalized and work plan developed. National Technical Officer has been recruited and trained.

Increased Public-Private & Public-Public Mix; Provinces for PPM have been selected: East, Central, West Java, DKI Jakarta, North Sumatra and South Sulawesi. Situation analysis tool (feasibility assessment) revised. Publication of the abridged ISTC in IDI journal is in progress. Translation of the full version has been finalized and amended by IDI.

Two senior staff has been recruited and is in place in provinces. Ten technical officers have been recruited, trained and posted in 5 provinces (DKI, West Java, Central Java, East Java and South Sulawesi) as DOTS coordinators in priority hospitals. In May 2007 a training course was carried out for technical officers. Specific HDL training was combined with the same course.

Expanded TB/HIV activities; First TB/HIV Sero-prevalence in Jogjakarta finalized. Survey protocol and toolkit has been developed.

Improved Human & Institutional Capacity; Two National Technical Officers have been recruited. They started implementing their work plans in December 2006. Two Technical Officers for drug management have been recruited. Recruitment for the prisons has started. Three National Technical Officers for TB/HIV have been assigned by FHI. TB Operational Research proposals have been reviewed and improved. Advanced Course for DOTS Acceleration carried out from February-April 2007. 17 senior staff successfully trained.