

Indonesia

Overview of TB control system

The decentralization of health services in Indonesia has challenged the TB programme to make major changes to operational procedures. Responsibility and management now lie at the district level, and the district health manager decides on funding for TB control, among competing health concerns. Political commitment for TB control must now be obtained from local governments. GERDUNAS, Indonesia's National Integrated Movement to Control TB established in 1999, serves as the equivalent of the Stop TB Partnership, and the NTP manager acts as executive secretary. GERDUNAS is a cross-sector movement, promoting the acceleration of TB control measures through an integrated approach, involving hospitals, the private sector, and other stakeholders. Primary health care continues to be seen as the most appropriate path to achieving universal TB control.

Surveillance, planning, operations

The steep rise in case notifications since 1996 can be attributed to improved case finding and better reporting: one third of the 62 396 additional cases notified in 2002 (compared to 2001) were detected by active surveillance in lung clinics that had not previously reported to the programme. Nonetheless, the estimated smear-positive case detection rate of the DOTS programme was still only 30% in 2002. This is very low, given that DOTS population coverage is nominally close to 100%. Treatment success increased markedly between 1999 and 2000 (because outcomes were evaluated for a much higher proportion of patients in 2000) and remained high in the 2001 cohort, exceeding the target value of 85%.

Indonesia's 5-year plan for 2002–6 continues to serve as the framework for TB control. The central unit for TB control was strengthened by the appointment of additional staff. However, more staff and training are needed in the provinces and districts so that newly-available funds will be used effectively.

GERDUNAS is well-established centrally, and plays a key role in national planning for TB control. Although GERDUNAS chapters were also established peripherally following high-level advocacy meetings held during 2002 in nearly all provinces, commitment has been variable since then. Management teams, in the form of provincial project officers and financial assistants, are being established in provinces to manage new donor funds. Over 900 management staff were trained at provincial and district levels to conduct training for

staff in health centres, though delay in receipt of donor funds and lack of district level plans slowed implementation in 2003.

DOTS expansion was delayed because GFATM funds, approved at the 1st round, were not disbursed until March 2003. Planned TBCTA activities in 7 provinces did not begin until late 2002 and early 2003. After a comprehensive external review of the NTP in January 2003, district work plans were prepared, taking into account the various projects supported by donors. 2003 was a productive year for DOTS expansion because of the additional funds and the development of these timely work plans.

Diagnostic capacity was improved by training laboratory technicians, through the purchase of microscopes and better quality reagents, and by strengthening quality control. Finalization, distribution, and implemen-

PROGRESS IN TB CONTROL IN INDONESIA

Indicator

• Treatment success 2001 cohort	86%
• DOTS detection rate, 2002	30%
• NTP budget available, 2003	91%
• Government contribution to NTP budget, including loans, 2003	61%
• Government contribution to total TB control costs, including loans, 2003	67%
• Government health spending used for TB, 2003	2%

Constraints to achieving targets

- Weak leadership and management capacity, inadequate financial management, and insufficient political commitment in some provinces and districts
- Interruptions in the supply of recommended drugs as a result of weak management and a lack of quality control
- Insufficient programme monitoring and surveillance due to weak reporting and supervision
- Limited involvement in DOTS outside health centres, with few public hospitals and private practitioners involved in TB control, and only 60% of staff trained in health units
- Slow disbursement of GFATM funds

Remedial actions needed

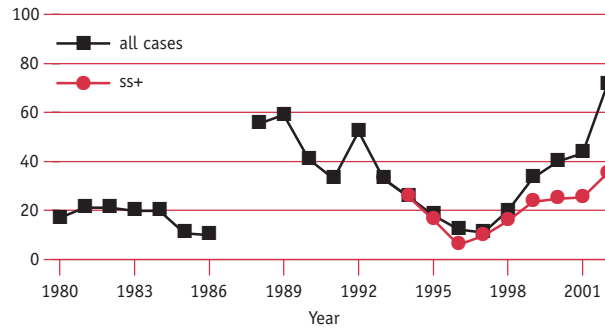
- Improve staffing, training, and quality of supervision at all levels
- Implement newly designed drug distribution and quality control system
- Increase the role of private practitioners and private facilities in TB control
- Train more health unit staff in DOTS treatment protocol

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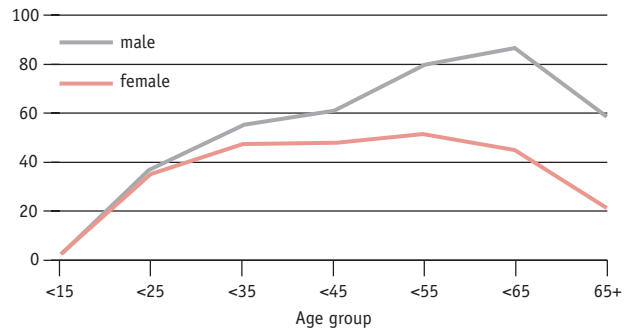
LATEST ESTIMATES ^a		TRENDS	1999	2000	2001	2002
Population	217 131 220	DOTS population coverage (%)	90	98	98	98
Global rank (by est. number of cases)	3	Notification rate (all cases/100 000 pop)	33	40	43	71
Incidence (all cases/100 000 pop)	256	Notification rate (new ss+/100 000 pop)	24	25	25	35
Incidence (new ss+/100 000 pop)	115	Detection of all cases (%)	12	15	17	28
Prevalence (ss+/100 000 pop)	272	Detection of new ss+ cases (%)	19	21	21	30
TB mortality per 100 000 pop	59	DOTS detection of new ss+ (%)	19	20	21	30
% of adult (15-49y) TB cases HIV+	0.6	DOTS detection of new ss+/coverage(%)	21	20	22	31
% of new cases multi-drug resistant	0.7	DOTS treatment success (new ss+, %)	50	87	86	—

Notification rate (per 100 000 pop)

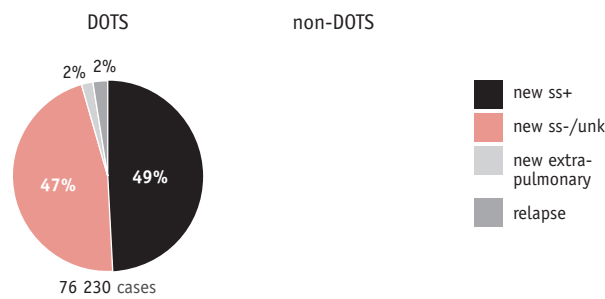
Notification (all cases) = 217 131 220 in 2002



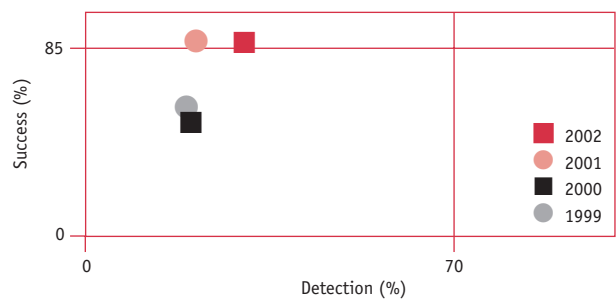
Notification rate by age and sex (new ss+)^b



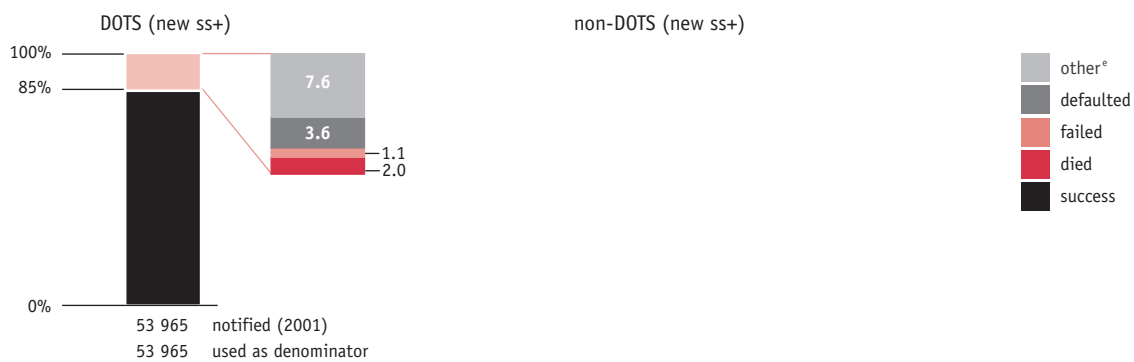
Case types notified^c



DOTS progress towards targets^d



Treatment outcomes^e



Notes

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

^a See Methods for data sources.

^b The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

^c Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

^d DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

^e "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

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tation of EQA guidelines started in 2003.

A proposal was approved for GDF support to introduce 4-drug FDCs in 4 highly populated provinces and to create a buffer stock of drugs. The drugs arrived in May 2003. Treatment outcomes ought to improve as a result of better drug management in these areas. A protocol to carry out a DRS survey was finalized, and the survey will be carried out in the near future.

The NTP has developed a national policy on PPM, and a plan to scale up activities. An evaluation was held in March 2003. Over 40% of the population seeks medical care from private providers, and there are several PPM initiatives in place to ensure that this care follows recommended procedures. A project linking hospitals to DOTS in Yogyakarta, for example, showed marked improvement in case notification. The Indonesian Medical Association has recently begun PPM pilot projects in 3 provinces.

Other initiatives to strengthen TB control included a national TB/HIV workshop, where draft recommendations were developed for coordinating TB and HIV activities, and where a TB/HIV working group was established centrally. However, there is no HIV surveillance among TB patients,

and no immediate plans to begin HIV testing. TB/HIV collaborative activities were piloted in just 4 out of 400 districts. IEC materials were developed and several community awareness campaigns were launched in connection with the World TB Day. Pilot projects were initiated by NGOs to strengthen community participation in DOTS. In the area of surveillance and case-finding, data collection from the network of lung clinics will become a routine part of reporting under DOTS.

Partnerships

WHO and KNCV are providing extensive technical support through 2 international staff based in the country and several national experts. In addition to the GFATM, Indonesia receives support from the Dutch government for staff training, from TBCTA and CIDA for DOTS expansion and strengthening of laboratories, from the ADB for overall strengthening of the health system, from the GDF for drugs, and from NLR for combined leprosy and TB control activities.

Budgets and expenditures

Expenditures by the NTP in fiscal year 2002 (from 1 January) were US\$ 18.2

million, the same as funding received. Most funding came from the government. Expenditures for items not covered by the NTP budget (i.e. clinic visits) are estimated at US\$ 4.2 million. Total TB control costs for 2002 can therefore be estimated at US\$ 22.4 million, or US\$ 148 per patient.

The NTP aimed to treat 220 000 patients in 2003, a 45% increase over the number in 2002. The NTP budget for the fiscal year 2003 allowed for this; at US\$ 31.9 million it was 75% higher than spending in 2002, thus increasing the budget per patient as case detection increases. The budget for 2003 was equivalent to US\$ 145 per patient, compared to US\$ 120 in 2002. The drug budget, at US\$ 7.7 million, was equivalent to US\$ 35 per patient. Most of the budget – US\$ 19.5 million – was covered by government funds, but grants were also important at US\$ 9.5 million. A funding gap of US\$ 2.8 million was reported. If the target of treating 220 000 patients was reached, costs associated with TB control that were not funded from the NTP budget would have amounted to an estimated US\$ 6.1 million. Total TB control costs would have been US\$ 38.0 million, or around US\$ 172 per patient.

Budget estimates, existing funding, and budget gaps for fiscal year 2003, US\$ millions

	REQUIRED FUNDING	EXPECTED FUNDING				FUNDING GAP
		GOVERNMENT	LOANS	GRANTS	OTHER	
NTP budget						
Drugs	7.7	6.2	—	1.5	—	—
Dedicated staff working exclusively for TB control	0.3	—	—	0.3	—	—
New activities to raise case detection and cure rates	3.2	—	—	3.2	—	—
Buildings, equipment, vehicles	1.4	—	—	1.4	—	—
All other line items	19.3	13.3	0.1	3.1	—	2.8
TOTAL NTP BUDGET	31.9	19.5	0.1	9.5	—	2.8
Costs not covered by NTP budget ^a						
Hospital stay	—	—	—	—	—	—
Clinic visits for DOT and monitoring	6.1	6.1	—	—	—	—
TOTAL COSTS NOT COVERED BY NTP BUDGET	6.1	6.1	—	—	—	—
TOTAL TB CONTROL COSTS	38.0	25.6	0.1	9.5	—	2.8

— Indicates zero; NA, not available

^a WHO estimates, data not provided by the NTP