Funding Request Form

Allocation Period 2020-2022

Tailored for National Strategic Plans (NSPs)

Refer to the "Tailored for National Strategic Plans (NSPs)" Instructions to complete this form.

Summary Information

Country(s)	Indonesia
Component(s)	Tuberculosis
Planned grant(s) start date(s)	1 January 2021
Planned grant(s) end date(s)	31 December 2023
Principal Recipient(s)	The Ministry of Health Republic Indonesia
Currency	USD
Allocation Funding Request Amount	USD 150,447,024.45
Prioritized Above Allocation Request (PAAR) Amount[1]	USD 86,004,573.68
Matching Funds Request Amount[2] (if applicable)	USD 9,999,978.68

[1]PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat.
[2]This is only relevant for applicants with designated matching funds as indicated in the allocation letter.

Section 1: Context Related to the Funding Request

To respond to the questions below, refer to the *Instructions,* NSPs, other national documents, and the Essential Data Table(s).

1.1 Context Included in NSPs and Other Reference Documents

Check relevant contextual areas included in NSPs, as applicable.For areas not included in NSPs,provide referenceto other relevant document(s) with respective page numbers or providea narrative in Section 1.2.

Key area	Check the box if in NSP	Relevant section(s) and/or page(s) in NSP	If not in NSP, referto another document (specifying page numbers) or refer to Section 1.2
Cross-cutting			
Health system overview	√	Chapter 2.1 Indonesian Contex; **P:24-25** Disease burden **P: 25-27** Indonesian Health Systems Other references: 1. Ministerial Decree No.374/MENKES/SK/V/2009 on the National Health System (page 1-32). 2. Presidential Instruction No. 72/2012 on the National Health System (page 1-7) 3. The Consolidated Report on Indonesia Health Sector Review 2018 by the National Planning Board (page 23-33). 4. State of Health Inequality Indonesia (page 7)	
Health sector strategy	√	Chapter 2.1 Indonesian Contex; **P:25** Health development strategy **P: 27-29** Health cost and financing Other references: 1. Mid-term Development Plan (RPJMN) 2020-2024 (page I.6 and IV.19) 2. Draft Ministry of Health Strategic Plan 2020-2024	
Community responses and systems	√	Chapter 2.1 Indonesian Context **P: 29 Community participation in health development** **P:49-50 Community participation** Other references: Minister of Health Regulation No 8/2019 on Community Empowerment for Health, page 5-7	
Role of the private sector	√	Chapter 2.1 Indonesian context Page 25: Indonesian health system Chapter 2.2; **P:43-46** Public-Private Mix Other references: 1. Quality Tuberculosis Care in Indonesia: Using Patient Pathway Analysis to optimize PPM collaboration, Journal of Infectious Disease, 216 S724-732, 2017 2. Improving Indonesia Health Outcome, The World Bank, 2018 3. Law no 44/2009 on Hospital (page 3) 4. Ministry of Health Regulation No 28/2011 on Clinic (page 9-10)	
Human rights-related	√	Chapter 2.1 Indonesian context **P: 29** Gender equality and fulfillment of human right	

barriers/inequities in access to health services		Other references: 1. Social Barriers To accessing Quality TB Service, Spiritia Foundation, 2019 2. Scaling up Programs to Reduce Human Rights-Related Barriers to HIV and TB services, The Global Funds, 2018	
Gender and age-related barriers/inequities in access to health services	√	Chapter 2.1 Indonesian context **P: 29**Gender equality and fulfillment of human right Chapter 2.4 Root cause analysis of problems along the continuum of care **P:56** People not accesing health service Other references: Social Barriers To accessing Quality TB Service, Spiritia Foundation, 2019	
Economic, geographic and other barriers/inequities in access to health services	√	Chapter 2.1 Indonesian context P: 23 Geography and population: Growth disparities between islands **P: 23** Economy and development: urban poverty that surpass rural poverty **P: 25** The mission of MoH to achieve a health, productive, idependent and just society. One of the mission is "increasing the availability, equity and quality of health resource" Other references: 1. Effect of financial support on reducing the incidence of catastrophic costs among tuberculosis-affected households in Indonesia: Eight simulated scenarios. Infectious Diseases of Poverty 8(1), 2019 2. Government Regulation No 2/2018 on Minimum Service Standards	
Role of community groups in the design and delivery of programs	√	Chapter 2.1 Indonesian context **P: 29** Community participation in health development **P: 49-50** Other references: 1. Guidelines for use of Village Development Funds for Health, Health Promotion Directorate, MoH (page 4-7, 31 and following) 2. Presidential Instruction No. 99/ 2017 on Initiative for Family Empowerment and Welfare (page 6-8)	
Linkage between disease specific NSPs and sector strategies	√	Chapter 1.1 Global and national commitments to end the epidemic of Tuberculosis **P: 16-19** Other references: 1. Mid-term Development Plan (RPJMN) 2020-2024 (page I.6 and IV.19) 2. Draft Ministry of Health Strategic Plan 2020-2024 3. National strategic on acceleration stunting prevention 2018-2024. National Committee on Poverty Reduction (page 22 and 29). Ministry of Home Affair Regulation no 33/2019 on local budgeting 2020 (page 129)	
Other			
Disease-specific			
Key stakeholders of NSPs and operational plan development	√	• Chapter 8 Roles of Stakeholders; **P:200-206** • Chapter 1.2 Frameworks and TB NSP development process; **P:19-21**	
Epidemiological profile	√	Chapter 2.2 The development and challenge of National TB Control Program 2016-2019; **P:30-32** The burden of tuberculosis	

		P: 32- 41 Notification and treatment of drug sensitive TB, drug resistant TB, TB-HIV, childhood TB Other references: 1. TB Epidemiological review, 2019 2. Country Profile on Global TB Report 2019, GTB	
Analysis of key, vulnerable and/or underserved populations	√	Chapter 2.4; Root cause analysis based on People Centre Framework; **P:56-62** Other references: Consolidated TB Data 2018	
Lessons learned from past program implementations	√	Chapter 2.2; The development and challenge of National TB Control Program 2016-2019; **P:30-55** Other references: Executive summary report of JEMM 2020	
Disease-specific national policies and guidelines	√	Chapter 5.1; Operational plan of tuberculosis control in Indonesia 2020-2024; **P:99-166** Other references: 1. Minister of Health Regulation No 67/2016 2. Minister of Health Regulation No 13 /2013 3. Minister of Health Regulation 350/2017 4. Minister of Health Regulation No 755/ 2019 5. National Guidance Medical Services fo TB	
Summary budget, including costing methodology and assumptions	√	Chapter 7 Budget and Financing; **P:193-199**	
Program's prioritization approach	√	• Chapter 4.3 Intervention approach for TB care and prevention 2020-2024: P:67-68 • Chapter 4.4 Intervention based on Continuum of Care; **P:69-79** • Chapter 4.6 Intervention Optimization**; P:85-86** • Chapter 4.7 Key interventionand activities; **P:86-98** Other references: 1. Acceleration Plan for Programmatic Management of DR-TB, NTP, 2019 2. TB-HIV Acceleration Plan, NTP and NAP, 2019	
Monitoring & evaluation plan	√	Chapter 6 Monitoring and Evaluation; **P: 187-192**	
Operational plans	√	Chapter 5.1; Operational plan of TB care and preventive in Indonesia 2020-2024; **P:99-166** Chapter 5.2; 5.2. Thematic intervention of tuberculosis control in Indonesia 2020-2024; **P:167-186**	
Other			

1.2 Contextual Information not Included in NSPs

For the gaps in question 1.1, provide information below.

[Applicant response]

Section 2: Funding Request and Prioritization

To respond to the questions below, refer to the *Instructions,* **NSPs, Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework, Budget and Essential Data Table(s)**. Includenarrative only if these documents omit required information.

2.1 Overview of NSPStrategic Areas

Completethe table below, referring to the relevantNSP page numbers, whenever possible. Ensure information is consistent withNSP cost details and analysis provided in **Funding Landscape Table(s)**.

NSP strategic areas	Key interventions (refer to NSP page numbers)	Baseline and targets (refer to NSP page numbers)	NSP funding need In the grant currency for implementation period of this funding request (USD)	Anticipated funding gaps % of need for implementation period of this funding request (**before** Global Fund contribution)
1. Strengthen government commitment and leadership in all level to eliminate TB in 2030	1.1 Developing and expanding of policies related to comprehensive TB control action plans at the district/city level	1.1 Percentage of provinces and districts with tuberculosis indicator in their strategic plans. B 2018: 10% T 2024: 90% **P:205**	**36,806,221.78**	**61**
	1.2 Ensuring district/city governments have optimal regulations and resources to control TB	1.2 Percentage of districts/cities that have sufficient funding to implement Minimum Service Standards for TB B 2018: NA T 2024: 70% **P:205**		
	1.3 Advocating government to address social factors related to TB			
	1.4 Standardizing TB service to form a service network that will facilitate a referral and quality assurance system			
	1.5 Optimizing the coalition role of professional organizations at the district/city and provincial levels in monitoring TB services, especially the TB service network			
	1.6 Establishment of professional organization network and TB patient organization			
2. Improve access to patient centered and good quality TB service	2.1 Optimizing early detection and control for drug-sensitive TB	MI.1 Treatment coverage of new and relaps TB cases B 2018: 67% T 2024: 90% **P:203**	**1.670.667.342,38**	**88**

		2.2 Proportion of TB cases detected by Rapid Molecular Testing B 2018: 20% T 2024: 75% **P:205** 2.6 Percentage of DM screened for TB B 2018: NA% T 2024: 50% **P:206** 2.7 Percentage of TB patient notified in Prison B 2018: 40% T 2024: 90% **P:206** 2.8 Percentage of TB index cases assessed under contact investigation B 2018: 21% T 2024: 90% **P:206**		
	2.2 Optimize early detection and treatment of drug-resistant TB	MI.4 Treatment coverage (enrollment) of DRTB cases among estimated DR-TB incidence B 2018: 18% T 2024: 80% **P:203** 2.3 Percentage of diagnosed DRTB patient among estimated DRTB Incidence B 2018: 38% T 2024: 85% **P:205** 2.4 Number of districts with available PMDT hospital B 2018: 209 T 2024: 514 **P:205**		
	2.3 Optimizing procedure for integrated diagnostic testing and treatment of drug-sensitive and drug-resistant TB	2.2 Proportion of TB cases detected by Rapid Molecular Testing		

		B 2018: 20% T 2024: 75% **P:205** 2.13 Number of C/DST referral laboratory B 2018: 12 T 2024: 24 **P:206** 2.14 Number of Health facilities with rapid molecular testing B 2018: 897 T 2024: 1,584 **P:206**		
	2.4 Ensuring TB-HIV coinfected patients are diagnosed and treated with antiretrovirals	MI.8 TB-patients who are aware of their HIV status (tested for HIV) B 2018: 37% T 2024: 80% **P:204** 2.5 Percentage of TB-HIV patients who receive ARV treatment during TB treatment B 2018: 40% T 2024: 100% **P:205**		
	2.5 Strengthening DPPM activities through expansion of high quality TB care and patient centered services within the scope of government-private activities to improve access to quality TB services	2.19 Proportion of case notification from non-NTP Public hospitals B 2018: 16% T 2024: 23% **P:207** 2.20 Proportion of case notification from non-NTP Private hospitals B 2018: 17% T 2024: 36% **P:207** 2.21 Proportion of TB case notifications from private doctors and clinics B 2018: 0.1% T 2024: 1.4% **P:207** 2.22 Treatment Success Rate at Private private facilities (hospitals, clinics, GP's) B 2018: 39%		

		T 2024: 90% **P:207**		
	2.6 Improving diagnosis and treatment of childhood TB at public/ private primary and secondary care.	MI.7 Treatment coverage of childhood TB B 2018: 53% T 2024: 90% **P:204**		
3. Infection control and achieve the highest coverage of TB preventive treatment	3.1 Implement TB infection control	3.4 Coverage of health facilities implementing TB Infection Control B 2018: NA% T 2024: 60% **P:208**	**159,742,353.73**	**52**
	3.2 Achieve maximum coverage of TB preventive treatment	MI.10 Coverage of TB preventive treatment in TB household contacts. B 2018: NA T 2024: 54% (out of 1,2 million eligible contacts) **P:204** 3.1 TPT Coverage of children under 5 B 2018: 10% T 2024: 90% **P:208** 3.3 TPT Coverage for PLHIV B 2018: 10% T 2024: 55% **P:208**		
4. Utilization of the effectively proven technology of screening, diagnosis, and treatment	4.1 Adoption of digital technology to strengthen the national TB program		**14,404,736.24**	**55**
	4.2 Coordination of research institution to implement TB research agenda in their research subjects			
	4.3 Advocacy to increase funding for TB research and innovation	4.3 Number of province implementing TB operational research B 2018: 5 T 2024: 25 **P:208**		
	4.4 Support research and innovation to support TB program	4.1 Number of policy brief generated from TB Research B 2018: 8 T 2024: 20 **P:208**		
5.Improve community, partner, and multi sectoral participation in TB elimination	5.1 Empower community by intensified IEC, especially on TB prevention	5.3 Number of districts have partnerships with community/CSOs to support TB program intervention B 2018: 235	**51,708,583.37**	**38**

		T 2024: 514 **P:209**		
		5.2 Number of province have linkage/ network with TB survivors B 2018: 12 T 2024: 34 **P:209**		
	5.2 High level coordination with Ministries and Provincial government			
	5.3 Improve community feedback mechanism on the TB service quality			
	5.4 Ensure response to the feedback of community, especially those affected by TB			
	5.5 Reduce stigma and discrimination to TB affected population or those with high risk of TB	5.4 Community referral contribution to total TB case notification (all cases-all forms) at health facilities. B 2018: 28% T 2024: 38% **P:209**		
6.Strengthen TB program management through health system strengthening	6.1 Improve the capacity of medical human resources for TB clinical and program management		**122,218,525.22**	**30**
	6.2 Sustained and integrated TB information system	6.1 Percentage of health facilities with timely and complete reporting B 2018: 60% T 2024: 90% **P:209**		
	6.3 Strengthen financing of TB program by engaging multiple partners with resources			
	6.4 Strengthen logistic management	6.2 Percentage of districts without episodes of drugs stock out 82% to 97% **P:209**		
NSP YEAR 2021-2023 TOTAL AMOUNT			**$ 2.055.547.762,72** 2021: $ 570,107,493.07 2022: $ 699,766,945.35 2023: $ 785,673,324.57	

2.2 Funding Request to the Global Fund

Fill in questions a) and/or b) as relevant for your country funding request approach(es):
a)for funding requests using the traditional,Performance Based Funding approach
b)for funding requests using the Payment for Results modality

All applicants should fill in questions **c)**, **d)** and **e)**.

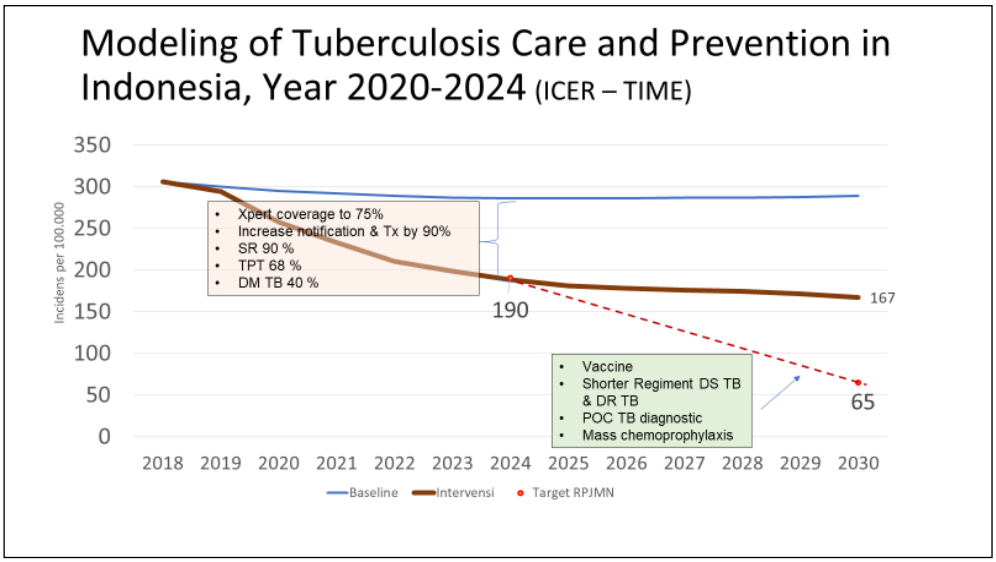
a)For a funding request using the Performance Based Funding approach:

Use the table below to list and provide the rationale for **each intervention** prioritized for Global Fund funding.

COMPONENT: Tuberculosis

Out of the NSP budget of A USD, we request GF allocation support of 150,447,024.45 USD, matching fund of **9,999,978.68** USD; and prioritized above allocation of 86,004,573.68 USD.
From the interventions planned in the NSP, the proposed activities for GF funding are based on the expected impact to the elimination target. The target was optimized by tuberculosis epidemiology modeling using Tuberculosis Impact Model and Estimate (TIME) that was combined by cost modeling to provide the Incremental Cost-Effectiveness Ratios of Intervenstions/ICER) applied during the period of 2020-2024.

Based on the estimation model, the TB incidence will decrease according to the NSP target if our implementations lead to the combination of:
1. Expansion of diagnosis using molecular rapid diagnostic by 75%;
2. Coverage of treatment of 90%;
3. Treatment success rate of 90%;
4. Coverage of TPT among household contacts by 68% in 2024, and
5. The coverage of TB screening among DM patients of 40%.



The model also suggests to detect at least 80% DR-TB cases, enrolled 95% detected case, and achieve 80% treatment success to reduce the DR TB incidence. Based on the current situation, the achievement of those targets will need enormous efforts while the funding gap is still huge.
The proposed interventions below are to support the achievement of or to get closer to those coverage, directly or indirectly. This was the results of series of consultative meetings with stakeholders: TB, HIV, and malaria program in MoH, community and civil society organization, Bappenas (The National Planning and Development Agency), Development partners (WHO, WB, USAID, DFAT) and other technical partners. The prioritization takes into account the recommendation of Joint External TB Monitoring Mission in 20-30 January 2020
The prioritization is explained in section 2.2b.
The format is strategic based, however, some activities can be integrated.

NSP Strategic Area1:**Strengthen government commitment and leadership in all level to eliminate TB in 2030**		
Intervention	Rationale for prioritization for Global Fund funding	Amount requested from the Global Fund
1.1 Development of comprehensive and inclusive district TB care and prevention action plans which are supported by relevant stake holders and authorities in 334 priority districts.	Districts play a major role in providing political support and resources for the TB care and prevention in their respective areas taking into consideration the decentralized nature of the	**$ 1,043,694.48**

Action plans will include operational activities, costed operational plan and specific indicators and targets to monitor the progress and ensure the accountability. The intervention activities at district level will include: 1. Regular intersectoral coordination meetings for development of action plans (estimated 2 meetings per district) 2. Producing TB programme annual reports highlighting achievement, lessons learnt and way forward to the district governments 3. Dissemination of the action plans with its annual targets to TB stakeholders in the district (district government, multi sectoral actors) *(intervention 1.1 in the operational plan chapter 5 of NSP: Developing and expanding of policies related to comprehensive TB control action plans at the district/municipality level)*	health system. The inclusion of TB indicator in the Minimum Service Standards (SPM) requires rigorous actions to be taken by the districts, that should be clearly written in an action plan. This intervention is a formal process to engage district governments in planning and putting resources for TB care and prevention activities. This intervention will contribute to strengthening the sustainability of the national disease response as GF support will be a catalyst to start this practice and an investment for future taking over by domestic funding. The proposed intervention corresponds to **"Coordination and management of national disease control programs"** intervention of the **"Program Management"** module of the GF modular framework and **"Routine reporting"** intervention of the **"RSSH: Health management information systems and M&E"**.	
1.2 Strengthen the capacity of 334 priority districts' government to improve implementation of TB care and prevention interventions in their governed areas 1. Funding for additional human resources to strengthen TB care and prevention interventions (1 technical officer, 1 data officer, 1 financial assistant for 292 high burdened districts and 1 data officer and 1 financial assistant for 42 high HIV burdened districts) *2.* Advocacy to the district government to establish local health and social protection scheme for TB patients, in addition to those already covered by the central government. *This will be part of the district action plan development activities* 3. Advocacy to the Ministry of Home affair (MoHA) to monitor and evaluate the achievement of minimum service standards (SPM) with "politically visible" sets of TB indicators. This will be integrated with HIV and malaria program in each overlapped area *(intervention 1.2 in the operational plan chapter 5 of NSP: Ensure district/municipality governments have optimal regulations and resources to control TB)*	There are potential resources from different ministries and stakeholders that can be allocated for TB care and prevention interventions. These include Dana Desa (village funding) of the Village and Rural Development Ministry, DAK (special allocation fund for health from central government) among others. JEMM 2020 observed the utilization of DAK in a district to enhance community mobilization which led to a substantial increase in TB diagnosis. Advocacy to the district government is to ensure funding for the implementation of district action plans including sufficient funding to cover enablers and allowance needed by TB patients. Advocacy to the MoHA is needed as MoHA monitors implementation of the SPM programme at the district level and may issue sanctions to the leaders of local governments that do not meet their targets. JEMM 2020 noted that due to the lack of staffs, the public health functions are not well taken care in districts, such as recording and reporting, supervision and performance monitoring, engaging public and private sector providers on quality of care issues, tracing patients lost to follow-up and ensuring continuity of care, contact investigation, screening in high-risk groups, preventive therapy, and facilitating social support to patients and their families. In addition to fulfilling public health functions, the additional human resources will allow the district TB coordinator to ensure strategic implementation, monitoring, and evaluation of district action plans and coordinate different stakeholders in TB care in the district. GF support is needed to pay the additional HR from 2021-2023 which will serve	**$ 8,163,624,30**

	as a model for the districts to allocate resource in their action plans (point 1.1 above). The provincial health office and MOHA as SR will be responsible to provide supervision and technical assistance for the development of District TB Action Plan (RAD). With the upcoming Presidential regulation for TB acceleration plans towards elimination which mandate allocation of sufficient HR and the engagement of MoHA, the NSP 2020-2024 will be translated into the District Action Plans that include the local HR needs supported by local resources allocation or special central government funds chanelled to districts. Provincial Planning Bureau and Directorate General of Regional Development of MOHA will be responsible to oversee the implementation of the district action plan, ensuring sufficient resources allocation for TB to met with Presidential regulation. We estimate that by theend of 2023, 25% high TB burden districts which have sufficient fiscal space can start the hand over process for HR.The proposed intervention corresponds to **"Coordination and management of national disease control programs"** intervention of the **"Program Management"** module and **"HRH policy and governance"** intervention of the **"RSSH"** module of the GF modular framework.	
1.3 Advocacy and coordination in central level to ensure harmonized regulation to support the implementation of interventions and financing for TB program that involved different ministries, institutions, and sectors 1. Advocacy to different departments of MoH to synchronize regulation barrier hampered TB program scale-up. This includes one coordination meeting 2. Advocacy to the Ministry of administrative and bureaucratic reform on human resource regulation (on mutation of civil servants, training and remuneration policies). This includes 1 national coordination meeting 3. Advocacy on labour law to adopt TB screening and management at the workplaces and employers obligation to continue employment of staff who are under TB treatment. The law on the arrangement of sick staffs exists, but may not always be implemented. The activities includes one coordination meeting per year following an assesment of cases supported by the paralegal and lawyers in 20 big industrial cities. The meeting aims for decisional purpose among the two ministries. The regular work of assesment	Some regulations pose barriers for implementation of TB care and prevention activities at different levels. For example, only 33 out of 878 Xpert machines are in private hospitals. Addresing the regulatory barrier to allow the provision of publicly recommended commodities to private providers will be helpful. JEMM 2020 observed that there is a regulation allowing the initiation of MDR-TB treatment only to clinicians specialized in internal medicine and chest medicine, making it harder to increase the number of treatment centers. The proposed intervention corresponds to **"Coordination and management of national disease control programs"** intervention of the **"Program Management"**module of the GF modular framework.	**$ 56,471.24**

and communication will be conducted by relevant staffs of each ministries, supported by communities. 4. Disemination of the Presidential decree that oblige people with DR TB starting treatment to the communities who will integrate this subject in their IEC activities *(intervention 1.3 in the operational plan chapter 5 of NSP: Advocate government to address social factors related to TB)*		
1.4 Coordination with BPJS on TB and MDR TB diagnosis, treatment, referral and quality of care: 1. Communication on screening, diagnostic and treatment algorithm and its financing implication. 2. Communication related to BPJS payment mechanisms for TB and MDR-TB after strategic health purchasing reform. 3. Advocacy to BPJS to cover the costs related to the management of omorbidities or adverse drug reactions and its financing implications *(intervention 1.4 in the operational plan chapter 5 of NSP: Standardizing TB service to form a service network that will facilitate a referral and quality assurance system)*	JEMM 2020 observed that BPJS payments increasingly drive priorities towards clinical care. From 2015 to 2018, the proportion of TB cases notified from hospitals increased from 26% to 46% and BPJS hospital claims for TB increased from IDR 334 billion (US$ 24m) to IDR 517 billion (US$ 35m). JEMM 2020 noted that there are diagnostic hurdles imposed by BPJS, for example the access to CXR that is part of the TB diagnostic and should be considered at the primary health care level. Development of performance-based, TB-specific BJPS payment mechanisms at the primary and secondary care levels becomes necessity and the inclusion of MDR-TB case-management into JKN/BPJS coverage is also a critical priority. Care and treatment financing from BPJS is a potential sustainable source of financing. These goals needs intense and frequent advocacy efforts and coordination at central and regional levels. This will address many barriers including improving the allocative efficiency and ensure that physically available services are also administratively accessible. The proposed intervention corresponds to **"National health strategies and financing"** intervention of the **"RSSH"** module of the GF modular framework.	**$ 25,412.06**
1.5 Improving quality of supervisory activities based on systematic risk-based assessment of disease burden and performance gaps to ensure high quality TB prevention, care, and treatment are provided by all health service providers. Risk based supervision will focus on program quality, data linkage and validation, logistic management (forecasting, quantification, supply planning, local procurement standard), accounting and financial reporting. The supervision will be delivered in more integrated and supportive manner by MoH and health office officials, hospital associations and medical professional representatives, public health experts, and relevant PR and SR staffs according to the identified risks in the districts. The proposed activities are: 1. Development of integrated supervision	JEMM 2020 noted that monitoring and supervision are relatively weak, unable to detect and address several programmatic challenges. Investment to set up quality assurance system of comprehensive TB care is needed to set up examples and standards. This intervention will be sustained by domestic funding in the future if we invest on good system and set up the examples. The current supervision methods and implementation need to be revised and shifted from solely implemented by district TB wasor into more open architecture and design. The systematic risk-based assessment will be conducted annually by TB program and PR/SR/SSR to design supervisory activities focus, frequency and timeline. Results of the supervisory activities will be reflected on budgeting and workplan development. A grading system based on programmatic and	**$ 206,256.14**

system with TB, HIV, and malaria program, including cascade system and tools. The development will be contracted to a technical assistance agency 2. Implementation of integrated supervision and monitoring the technical quality of TB care and the program management at different levels of services, based on the developed supervision system. (quarterly supervision visit from the national TB program and PR to province and 3 supervision from PHO and SR per district and SSR, depend on the annual risk assessment developed by program and PR/SRs)) 3. Regular supervision and monitoring for TB case notification at all health service providers by District TB Team (based on the risks possessed by health facilities.) *sub intervention 1.2.3 in NSP:* Develop policies/regulation related to human resources to ensure recording and reporting of Tuberculosis, including in private health care providers *sub intervention 1.2.4 (*Conduct routine monitoring and evaluation of the tuberculosis control related minimum service standards) *in the operational plan chapter 5 of NSP*	management performances will be expanded to SSRs and health facilities, The proposed intervention corresponds to **"Analysis, evaluations, reviews and transparency"** intervention of the **"RSSH"** module of the GF modular framework.	

NSP Strategic Area 2: **Improve access to patient centered and good quality TB service**		
Intervention	Rationale for prioritization for Global Fund funding	Amount requested from the Global Fund
2.1 Integrate TB case finding in different program, such as: HIV, MCH, pediatrics, and non communicable disease (NCD) services, through collaboration, integrative capacity building and coordination activities which are initiated by TB control program: 1. Train 2 DHO staff health workers and 2 health workers in primary health centers (Puskesmas) in primary health centers (Puskesmas) in 334 districts to conduct integrated TB screening in PLHIV, DM patients, patients with immunosuppressed condition, pregnant women, people with mental health, and smokers 2. Train 5 health workers in 334 hospitals for intensified TB screening at non TB clinics. 3. Cross program coordination meetings at district level 4. Comprehesive screening in the above mentioned services, including CXR screening for 400.000 diabetic patients per year 5. Monitoring and evaluation of integrated	To support TB case detection among attendance of non TB services at primary and secondary care providers, NTP propose to integrate TB screening as standard package of other disease control program. In Indonesia, people with HIV, diabetes and older persons, as well as smokers, are particularly vulnerable to TB. JEMM 2020 recommended that patients with high risk of getting TB should be considered for intensified case finding using the most sensitive technologies (digital chest x-ray and Xpert). Screening program is not covered by the health insurance, but the disease diagnosis among presumptive patients will be covered. GF support is needed to cover the screening activities. The proposed intervention corresponds to **"Collaborative activities with other programs and sectors"** intervention of the **"TB care and prevention"** module of the GF modular framework.	**Allocation:** **$ 163,653.67** **Matching fund** **$ 8,366,053.81**

services at the district and provincial levels (integrated with comprehensive monitoring and evaluation) *Intervention 2.1 of NSP: Optimize early detection and control for drug-sensitive Tuberculosis* *Intervention 2.5. Ensure TB-DM patients diagnosed and treated by anti-tuberculosis*		
2.2 Active case finding in the population with high risk of TB exposure (estimated TB prevalence ≥ 1%) The activities includes CXR screening and sputum examination with rapid diagnostic test (GeneXpert) in selected populations: prison inmates We expect to screen about 250,000 inmates per year *Sub intervention 2.1.8 of NSP: Conduct Tuberculosis active case findings in congregate setting i.e. prison/detention center, closed mines, refugees' barrack, boarding hall and religious boarding school*	JEMM 2020 recommended using mobile TB screening and testing using vans fitted with Digital CXR-Artificial Intelligence to read the image and confirm the diagnosis with the rapid molecular tests. We prioritize GF request to conduct CXR screening among prison inmates because it is not covered by the national insurance. With a good example of ACF activities in prison, the activities will be expanded to other population and will be handed over to the district governments. The proposed intervention corresponds to **"Case detection and diagnosis"** intervention of the **"TB care and prevention"** module of the GF modular framework.	**$ 3,176,507.51**
2.3 Intensify household contact investigation, coupled with early diagnosis and treatment of TB and early provision of TB preventive treatment for eligible household contact. The intervention will include: simple algorithm, conducting symptom screening, Tuberculin test, and initiation of TB preventive treatment at home for under 5 year-children. The activities include: 1. Disseminate guidelines in the Puskesmas 2. The community cadres coordinated by the Puskesmas conduct household contact investigation of bacteriologically confirm TB patients (performance based reward) 3. The community cadres coordinated by CSO will conduct contact investigation among non household close contacts (performance based reward) 4. Monitoring and evaluation of activities 5. CXR screening for above 5 year household contacts in 25 highest burden districts under PAAR. We estimate to screen 200,000 contacts *Sub intervention 2.1.4 of NSP: Conduct contact investigation on Tuberculosis index cases*	Indonesia has adopt the WHO latest guidelines on programmatic management of LTBI and intensify contact screening. The development process of the guideline and action plan had been initiated in 2019 with funding supports from WHO. The current household and close contacts investigation has yielded in finding 7% TB cases among household contacts. The new approaches need more financial support to arrive on effective model that can be handed over to the district funds or health insurance in the future. The PFs related with contact investigation and TPT have been selected. The proposed intervention corresponds to **"Case detection and diagnosis"** and **"Prevention"** intervention of the **"TB care and prevention"** module of the GF modular framework.	**Allocation: $ 6,816,492.50** PAAR: $ 1,059,037.02
2.4 Develop and implement integrated digital adherence technology to support treatment monitoring and improve adherence of TB patients with estimated high risk to discontinue	The use of technology that improve program effectiveness is an important approach. There are evidences that IDAT is effective in improving adherence. Care providers and	**$ 70,802.49**

the treatment. The activities include: development of the program or apps, testing the program, and dissemination to the population *Sub intervention 2.1. of NSP: Adoption of new technologies in monitoring of Tuberculosis treatment*	community support groups demands and proposed the support as this is a new area that has potential to improve treatment outcome of TB/ DR-TB patients. The proposed intervention corresponds to **"Treatment"** intervention of the **"TB care and prevention"** and **"MDR TB"** modules of the GF modular framework.	
2.5 Strengthen the TB screening and diagnostic algorithm, incorporating sensitive screening methods (ex. CXR) and rapid moleculer test (GeneXpert) 1. Updating the TB screening and diagnostic algorithm 2. Organize effective sputum transportation level, based on the available courier system in the area (including public and private hospitals) Sputum transportation is organized from non GeneXpert Puskesmas to health facilities with GeneXpert and to DST laboratories if Rifampicin Resistance is detected *Sub intervention 2.1.15 in the operational plan chapter 5 of NSP: Improve access of tuberculosis case detection through rapid diagnosis* *Intervention 2.3 Optimize procedure for integrated diagnostic testing and treatment of drug-sensitive and drug-resistant Tuberculosis*	Effective diagnostic algorithm and its supporting system play a big role in improving TB case detection. The current specimen transportation system supports 4,432 health facilities, 203 districts in 16 provinces, roughly half of the country. The system utilizes the national post office couriers system and a mobile based application, SITRUS, to track samples. More than half of the districts (about 311 out of 514) are without specific specimen transport system for GeneXpert testing. This had an impact on detection of TB and DR-TB. In 2019, about 47% of RR-TB patients had phenotypic DST results and only 35% of patients enrolled in PMDT services had rapid second line LPA results. The lack of access to reliable specimen transport system is one of the key reasons for these low rates of testing for drug resistance. GF support is needed because the activity is important and no current national source is identified The proposed intervention corresponds to **"Case detection and diagnosis"** intervention of the **"TB care and prevention"** module of the GF modular framework.	**$ 1,335,319.05**
2.6 Enhanched diagnostic capacity and quality to detect all types of TB cases: 1. Develop and update laboratory guidelines, SOPs, manuals etc. follows latest recommendation for TB Laboratory. 2. Renovation of culture and DST laboratories to meet the required number of laboratory needs, balance distribution of laboratories and reducing burden for sputum transportation. We aim to expand culture laboratories from 21 to 46 and the DST lab from 12 to 24 to reduce the complexity of specimen referral. 3. Adding the 933 GeneXpert machines for primary care providers, increase capacity of FL and SL-LPA in 7 labs, maintain capacity of culture and DST labs: • Cartridge procurement, especially those with 2nd line drugs resistance test • Upgrade softwares or reporting systems	Limitations in access to GeneXpert testing and universal DST for rifampicin were observed during the JEMM 2020. Only 878 GeneXpert sites operate compared to 7,417 microscopy sites. Only 13% of new and re-treatment TB patients received DST for rifampicin, which is too low and impedes quality of care for managing rifampicin resistant TB. Access to the other DSTs and second-line LPA also remains low. Therefore, there are needs to expand Xpert, culture, DST and LPA services. Lack of implementation of real-time monitoring and connectivity solutions on GeneXpert systems (e.g., GxAlert, DataToCare etc.,) led to additional barriers in prompt DR-TB treatment initiation. The current domestic funding mainly allocated for cartridge/reagen procurement, therefore that funds is not sufficient to fulfill the required standards of laboratories for TB and MDR TB diagnosis and treatment follow up. More machines will be allocated in 291 high burdened districts at primary care facilities to be more inline with the health insurance referral mechanism. districts from 1:50 to ideal ratio of	**Allocation: $ 25,477,755.90** PAAR: • $ 2,035,322.48 for TrueNat procurement; • $ 21,510,244.56 for procurement of 633 GX to achieve total DST coverage in high burden TB districts and selected high TB burden area among low burden TB districts with high DM and HIV incidences, including cartridge and connectivity solution.

• Machines procurement (MGIT, GeneXpert). Additional 933 machines are requested (*633 will be in included in PAAR*) • Xpert diagnostic connectivity solutions • Maintenance of equipment and tools 4. Training/ Re-training of laboratory staffs, including technical assistance/mentoring 5. Update and implement QA system for all applied diagnostic tests 6. Establish one WHO GLI TB center of excellence to support network expansion and streamline quality assurance leadership in the country 7. Implement laboratory information system integrated with SITB 8. Laboratory monitoring and evaluation meetings 9. Small scale implementation of new rapid molecular testing available (i.e. truenat) in 20 Puskesmas with low workload (*will be included in PAAR*) *Sub intervention 2.2.3 in the operational plan chapter 5 of NSP Increase access to bacteriologic culture testing and first- and second-line drugs sensitivity testing, in patients with high-risk for MDR and XDR-Tuberculosis;* *sub intervention 2.2.4: Develop laboratories that can conduct rapid testing for second line Tuberculosis drugs at healthcare facilities, and facilitate the utilization of these laboratories* *Intervention 2.3 Optimize procedure for integrated diagnostic testing and treatment of drug-sensitive and drug-resistant Tuberculosis*	1:5. With the additional GeneXpert machines, 2091 health facilities can conduct TB and RR diagnosis. Since most of the TB patients are treated in the primary health care (Puskesmas), Rifampicin resistance test should be accessible in Puskesmas. This is the need to achieve 75% coverage of TB patient received RR diagnosis The proposed intervention corresponds to **"Case detection and diagnosis"** intervention of both **"TB care and prevention"** and **" MDR-TB"** modules of the GF modular framework.	
2.7 Providing HIV testing in TB services in Puskesmas and district hospitals in 234 TB-HIV priority districts. The activities include: 1. HIV testing training for TB staffs in the area that is not covered by HIV program 2. Technical support and mentoring on TB-HIV management 3. Support referral system of confirmed TB-HIV case for ARV initiation 4. Develop pocket book for community health workers and patients on the TB-HIV care that the patients will need to access (test, treat, TB preventive treatment) 5. Improve coordination with HIV program and intensify data validation at health	Programmatic data of the ministry of health indicated that in 2019, 37% of TB patients knew their HIV status and only 40% of TB/HIV co-infected patients were provided with life-saving ART. The coverage of CPT has been fluctuating since 2015, in 2019 only 39% of the TB HIV patients received Cotrimoxazole. The proposed approach is to enable TB service to conduct HIV testing and support patients referral to ARV centers (transportation support and buddies support). GF support is needed to improve the TB/HIV collaborative activities and enable the government to prepare for further taking over financial costs. The proposed intervention corresponds to **"Screening, testing and diagnosis"**, **"TB/HIV collaborative interventions"** and	**$ 3,457,909.02**

facility and district levels. I*ntervention 2.4 in the operational plan of NSP: Ensuring TB-HIV coinfected patients are diagnosed and treated with antiretrovirals*	**"Community TB/HIV care delivery"** interventions of **"TB -HIV"** module of the GF modular framework	
2.8 Coordination with the Ministry of Labour and BPJS ketenagakerjaan to enable access to social protection for TB and HIV patients -2 advocacy meeting per year in national level -1 advocacy meeting per year in 334 districts *Sub intervention 2.4.6 of NSP*: *Improve the psycho-socio economic support for patients with TB-HIV*	TB and HIV patients may be absent from their work when they are very sick because of the disease and drugs side effects. Social security is needed to ensure salary payment during sick time. At the same time, a win-win solution is also needed for the employers not to lose their business because of the long absence of the staff. No other funding source identified for this advocacy activities.The proposed intervention corresponds to **"Collaborative activities with other programs and sectors"** intervention of the "**TB -HIV"** module of the GF modular framework	**$ 782,886.28**
2.9 Ensure nationwide scale-up transition from intermitten dose to daily dose regimen for Drug Sensitive TB patients: • Phase out intermittent dose treatment regimen • Procurement of daily use DS-TB drugs o Procure 20% drugs needed for 2021 and 2022 o Procure 10% of buffer stock in PAAR *Sub intervention 2.1.14 of NSP: Treatment as per standards*	This is long pending issue for NTP Indonesia. The JEMM 2020 clearly recommended to phase out intermitten dose regimen as soon as possible. Having the evidence that domestic drug manufactures only ready after 2021, NTP will need supports from GF to procure 20% of drugs needed for 2021 and another 20% for 2022. The procurement of of daily regimen will be taken over gradually by GOI in 2022 when the GOI will start to procure 30% and expand to 100% at 2023. The proposed intervention corresponds to "**Treatment"** intervention of the **"TB care and prevention"** module of the GF modular framework	**Allocation: $ 8,100,284.74** PAAR: $6,075,213.56
2.10 Provide enablers and treatment support to facilitate diagnosed average 15,600 MDR TB patients to start treatment per year. (The exact number follows the number written in programmatic gap and PF). In the year 2021, the MoH PR will manage the distribution in enablers as the new community PR needs time to set up the system and to achieve sufficient performance of the planned interventions. In 2022-2023, the community PR will take over the distribution of enablers in 190 districts and MoH PR continue the distribution in the other districts. The system of transfer will be set up in 2020, including the verification system integrated in the role of case manager in PMDT health facilities *sub intervention 2.2.6 of NSP: Provision of patient-centered care for all drug-resistant Tuberculosis, including support for treatment adherence*	The number of MDR/RR-TB cases enrolled on treatment is decreasing year by year; it was 1879 (69%) in 2016, 3042 (60%) in 2017, 4360 (54%) in 2018, and 4690 (48%) in 2019. One of the bottlenecks observed by a study conducted by CTB in 2018-2019 and further confirmed by the JEMM 2020 team was the patients' unability to attend MDR-TB services to start treatment because of transportation and other costs. The strategy to increase enrolment rate has been included in PMDT acceleration plans by introducing community supports earlier and provision of transport allowance for all confirmed cases to attend DR-TB services since confirmation of DR-TB rather than at the time of treatment initiation. This proposed intervention is a temporary measure and later social protection costs will be absorbed by the government once patients will receive social assistance or insurance from various government sources. The proposed intervention corresponds to "**Treatment"** intervention of the "**MDR TB"** module of the GF modular framework	**Allocation: 17,839,266.18** PAAR: $14,866,055.15

Sub intervention 2.2.15 of NSP: Increase psycho-socio-economic support in patients with drug-resistant Tuberculosis. *Sub intervention 2.2.11 of NSP: Strengthen education and peer group in health care facilities since the drug-resistant confirmation to treatment completion by giving counseling to improve access to treatment and treatment adherence* *Sub intervention 2.2.13 of NSP: Strengthen the role of the community and former tuberculosis patients to improve treatment outcomes of drug-resistant Tuberculosis*		
2.11 Decentralize MDR TB treatment initiation in high TB burden area: 1. Increase capacity of 233 district hospitals to initiate treatment: • Instalation of DR TB information system in the new PMDT center • Distance learning or on the job training for the staffs in the new PMDT centres 2. Decentralize treatment continuation in Puskesmas o Distance learning or on the job training for the staffs in the new PMDT centres 3. Increase access to diagnosis (GeneXpert and DST) and treatment of DR-TB in private hospitals and non NTP public hospitals, i.e: prisons hospital and the hospitals under Armed Forces and National Police. *sub intervention 2.2.6 of NSP: Provision of patient-centered care for all drug-resistant Tuberculosis, including support for treatment adherence*	JEMM 2020 recommended to establish additional PMDT treatment centers to bring service of treatment initiation closer to patients. JEMM also recommended to explore community-based supportive model of care of MDR/RR-TB. . NTP proposes to set up DR-TB treatment initiation centers in each district and treatment continuation in Puskesmas. With current PMDT acceleration plan there will be 360 DR-TB hospitals at 281 districts, so additional 233 DR-TB hospitals are needed. In addition to district hospitals and puskesmas, strengthening DR-TB diagnosis and treatment in private, prison, police, and armed force hospitals is also needed. The proposed intervention corresponds to **"Treatment"** and **"Engaging all care providers"** intervention of the **"MDR TB"** module of the GF modular framework	**$ 970,211.98**
2.12 Provide comprehensive MDR TB treatment: 1. Procure longer and shorter oral regimen for MDR TB patients (2. Update guidelines, including aDSM guideline 3. Counseling training for health workers focus on patient centred approach 4. Strenghten country platform on Pharmacovigilance by conducting aDSM: training, data analysis, reporting, and coordination of drugs adverse reaction. The training will be provided to pharmacists in the facilities providing DRTB treatment	Current GOI allocation for TB program is not sufficient to covers the increase numbers of SLD procurement as targeted. Moreover GOI has regulation difficulties to procure the non registered SLD drugs with domestic fundings. However with new presidential initiative, GOI is willing to increase budget allocation for health products by 2023 and beyond. Under the FR, SLDs will be requested for around 5055 MDR TB patients per year for 2021-2022 under grant allocation and the rest of volume to complete 50% of the drugs needs for 3 years are requested under PAAR. The GOI will start procurement for 100% of SLD by 2023. NTP realize that this is not easy and needs very strong advocacy but this is consider	**Allocation: $ 12,879,762.24** PAAR: $ 19,166,358.46 for procurement of additional SLDs

Sub intervention 2.2.5 of NSP: Implementation of new guidelines and new drugs in Tuberculosis treatment to improve the quality of drug-resistant Tuberculosis care in Indonesia *Sub intervention 2.2.9 of NSP: Strengthen the Pharmacovigilance national committee*	as a should do business. JEMM 2020 noted that management of adverse reactions was inadequate, and technical support on clinical management was rarely provided to PMDT treatment sites. The reviewers recommended that pre-treatment counseling should be strengthened through training and supportive supervision, focusing on positive aspect of treatment in order to encourage treatment uptake. These activities are part of the patients centred approach which will have a positive impact on the reduction of DR-TB treatment gap and increase of treatment success. The proposed intervention corresponds to **"Treatment"** intervention of the **"MDR TB"** module of the GF modular framework	
2.13 Development of attractive, comprehensive and effective IEC materials and campaign: Social media campaign *Sub intervention 2.2.11 of NSP: Development of educational Information, Education and Communication (IEC) material for patients with drug-resistant Tuberculosis related to drug adverse events (for health workers and the community)*	The result of the prevalence survey 2013-2014 shows that 43% people with TB symptom not seeking for health services and 31% performed self-medication. Those facts have contributed to treatment delays and the low TB treatment coverage with only 67% (61-73%) in 2018. NTP has the target to notify 85-90% of TB cases in 2021-2023, therefore, the health seeking behavior of TB patient need to be addressed. Comprehensive IEC materials to educate patients and community health workers will enable them to demand good standard of service, provide feedback of quality, and the most important to understand and follow all recommended procedures for succesful treatment outcome. The IEC materials should be attractive and massive. The MoH budget through the health promotion department has been allocated for all health issues. Therefore it is not sufficient to finance TB IEC materials on the quantity and quality required to get the impact we expect. The proposed intervention corresponds to **"Case detection and diagnosis"** intervention of the **"TB care and prevention"** module of the GF modular framework.	**$ 741,185.09**
2.14 Result based rewards for health facility staffs in managing DR-TB patients. Specific reward for enrolling a diagnosed patient into care and for following up until the treatment is completed *Sub intervention 2.2.2 in NSP Accelerate the expansion of drug-resistant Tuberculosis treatment services that meet the standards in all districts/municipalities* *Sub intervention 2.2.8 in NSP Ensure the provision of qualified and standardized drug-*	JEMM 2020 has identified a systematic neglect of DR-TB HCW. The motivation of the health facility staffs to achieve the detection, enrollment, and treatment completeness targets is very important. Under current health system rewards system, there is no additional weighting for benefits if health care workers take care for the MDR TB patients . Several self-financial managed hospitals (BLUD) in Central Java (i.e. Muwardi hospital) successfully integrated this incentives based on their merit based rewards system with significant impact on their overall performances	**$ 1,977,905.34**

resistant Tuberculosis services to increase the success rate of treatment	(2015-2017), however this is a very fragile gain since the decision was taken only with local management decision not by system. NTP proposes a reward system based on results to improve the motivation of health staffs, for example: specific reward for DR-TB confirmation, DR-TB enrollment, and DR-TB treatment completeness. NTP can later present the evidence on positive impacts of reward system to the improvement of service quality to the government structures and bargain for the provision of incentive scheme for health facility staffs to perform the public health functions either under government or health insurance scheme. The introduction of service package payment system of BPJS under the strategic health purchasing reform opens an opportunity to insert this insentive scheme on payment for performance mechanism, for that a solid evidence is needed The proposed intervention corresponds to **"Case detection and diagnosis"** and **"Treatment"** interventions of the "**MDR TB"** module of the GF modular framework.	
2.15 Implement comprehensive quality assurance system on MDR TB services: • Clinical audit/ mini cohort to monitor enrolment, decentralization process and patient centred approach implementation • Establish regional/provincial consilium for DR TB management. The QA and clinical mentoring will be delivered by the provincial team consisting of leading PMDT clinicians. • Clinical mentoring *Sub intervention 2.2.8 of NSP: Ensure the provision of qualified and standardized drug-resistant Tuberculosis services to increase the success rate of treatment*. *Sub intervention 2.2.10 of NSP:* Carry out an audit of the patient's death from drug-resistant Tuberculosis which is followed by monitoring the evaluation of a serious unwanted event.	Strong teamworks at health facility level should be engaged to manage DR-TB patients correctly. The general treatment outcome of DR-TB patients is low, due to irregular team monitoring and cohort analysis. JEMM 2020 recommended that provincial consilium provide mentoring on clinical management of MDR/RR-TB at treatment cites and in the community. The provincial consilium will be under the guidance and support of national consilium. The cost for this approach is less than the cost of the current approach that the mentoring is provided by the central level. No current domestic funding source is available for this intervention. The proposed intervention corresponds to **"Case detection and diagnosis"** and **"Treatment"** interventions of the "**MDR TB"** module of the GF modular framework.	**$ 1,081,982.84**
2.16 Strengthen effective and accessible referral system through partnership with health service providers under different ministries and private sectors (PPM). The activities include: In district level: *1.* Engage a technical staff to coordinate the activities *(is budgeted under district health office strengthening in strategy 1)* 2. Include TB staffs from PPM facilities in	In Indonesia, more than 70% of TB patients seek care in the private healthcare sector. There are more than 2,600 private hospitals, more than 50,000 private GPs and 25,000 pharmacies. Patients initially seek care with pharmacies and GPs, but an increasing proportion end up being treated in private (and public) hospitals. JEMM 2020 recommended to mobilize resource to hire a fully paid dedicated technical staffs to facilitate and coordinate	**Allocation: $683,486.98 Matching fund $1,633,924.87**

any TB training (possible co-financed by the private providers) 3. Coordination with professional organization and providers 4. Strengthen TB referral system following BPJS system, with coordination on conflicting regulation that complicates TB treatment access. 5. Engage community health workers to support adherence and contact investigation for TB patients in private health facilities In central level: 1. Setting up guidelines of work, logistic, monitoring, and evaluation 2. Setting up incentive system to attract providers engagement in TB control 3. Coordinate with BPJS to implement performance based payment to health facilities and GPs 4. Link BPJS TB data to SITB 5. Coordination with the owner, association, or the chain holders organization of health facilities networks. the current models (including DPPM) will be assessed by independent group and an appropriate models will be developed before grant making this year and this will inform the exact implementation of PPM activities. Other than the activities listed in this article, related PPM activities are included in the other articles, such as : implementation of sputum transportation system in article 2.5, improvement of electronic reporting system for private clinics and doctors in article 6.4. *Intervention 2.6 of NSP. Strengthen DPPM activities through expansion of DOTS services within the scope of government-private activities to improve service access and thematic intervention on PPM*	DPPM implementation to urgently expand the scope of the PPM initiative, targeting at least a 10-fold increase in GP engagement and a 2-fold increase in private hospital engagement. JEMM 2020 also recommended that the MoH, BPJS and their partners should develop systems to ensure seamless inter-operability of all relevant data systems. NTP proposes to strengthen the DPPM approach with close collaboration of BPJS, professional organization and providers association, which focus at 334 priority districs. This approach will be effective to increase TB case notification and apply high quality standards on TB care in all health facilities. The hospital association as one of the key PPM stakeholders proven has a strong potential to be engaged in shifting some PPM managerial burden from program. The GPs are engaged through BPJS system, therefore the coordination with BPJS is the key to strengthen GP case notification and apllication of standards of care and treatment according to the National Guidelines. With the issue of Presidential decree on TB elimination 2030, the District Government will mobilize the resources to achieve case detection and treatment targets The proposed intervention corresponds to **“Engaging all care providers”** intervention of the “**TB care and prevention”** module of the GF modular framework.	
2.17 Technical assistance for National Tuberculosis Control Programm through Intensified Technical Assistant and Support for Tuberculosis II (ITAS-TB II) provided by WHO which focus on: PPM optimization, PMDT scale-up, LTBI expansion, TB-HIV strengthening, Strategic capacity building for human resources and Health information for strategic action. (see attached detail TAs provided, deliverables and timetable in annex 1)	To achieve ambitious but reasonable targets on TB case finding, DR-TB expansion and newly designed TB preventive treatment, National TB Program needs a strong and continuous technical assistance from well-known technical agency which have strong experienced in TB control program in Indonesia. Under NFM 2018-2020, WHO provide technical assistance to NTP to strengthen TB platforms by strategic plan developments, tools review, strategic epidemiological data collection and establishment and pilots of new TB information system and deliver independent program review. The level of commitment and approach	**$ 2,500,087.88**

	will be continued under similar arrangement for 2021-2023.	

NSP Strategic Area 3: **Infection control and achieve the highest coverage of TB preventive treatment**		
Intervention	Rationale for prioritization for Global Fund funding	Amount requested from the Global Fund
3.1 Enhanced implementation of TB infection control in health facilities: 1. Technical support on TB infection control to health facilities treating TB patients 2. Multi sectoral coordination on TB infection control to advocate other sectors in setting up measures that prevent TB infection, for example: the Ministry of Public Works on adding ventilation in the TB patient's house, to the district government to put windows and ventilation requirement for construction permit 3. Procurement of personal protection tools (particulate respirator) 4. Set up monitoring and evaluation system on the implementation of FAST for TB infection control *Intervention 3.2 in NSP: Preventing and controlling tuberculosis infection*	Many activities of TB infection control do not solely depend on the health sector, so coordination is needed especially for important intervention such as environmental control. Coordination and advocacy are to sensitize the other relevant sectors to use their authorities and resources to conduct these interventions. The personal protection measures needs GF support because the cost of intervention can not be covered from domestic funding only, as particulate respirator are limited for key health facility staffs and not allocated for community health workers. The proposed intervention corresponds to **"Prevention"** intervention of the "**TB care and prevention"** and **" MDR-TB"** modules of the GF modular framework.	**$ 2,009,017.49**
3.2 Implement LTBI management and TB preventive treatment to population with high risk on developing TB: 1. Develop disseminate LTBI management guidelines its SOP and communication strategy 2. Provide training on LTBI management and the related logistic and monitoring and evaluation. The sensititation of human right barrier, including stigma and discrimination will be included in the subject (as health workers need to visit regularly the house of a patient) 3. Workloads implication assessment for health care workers 4. Procure Tuberculine Skin Test (TST) to complete TB diagnosis for children below 5 years (*allocation)*, and to confirm TB infection for above 5 year household contacts in 292 priority districts (*will be requested under PAAR)* 5. Procure 3HP for under 5 year and above 2 year household contacts and PLHIV 6. The INH for the under 2 year household contacts will be procured with national budget.Procure 3HR for above 5 year household contacts, to cover 100%, 60%,	JEMM 2020 recommended that the NTP should develop strategic communication plan to inform all stakeholders of the importance of TB preventive treatment as a lifesaving intervention. JEMM also recommended that the NTP should develop the capacity of health care workers to offer TB preventive treatment, including counselling and proper management of adverse events and expedite introduction of shorter regimens such as a 3-month weekly rifapentine plus isoniazid and a 3-month daily rifampicin and isoniazid. The support of GF is needed to cover the TPT of under 5 year household contacts and PLHIV. To cover the needs of TPT of above 5 year household contacts, we propose to procure 3 RH under PAARThe proposed intervention corresponds to **"Prevention"** intervention of the "**TB care and prevention"** module of the GF modular framework.	**Allocation $ 5,929,306.93 PAAR: 6,705,829.73 for 3RH for TPT of above 5 year household contacts 9,926,585.97 for tuberculin test of above 5 year household contacts**

and 40% the needs to fulfill NSP target in PAAR. The rest will be covered by the government *Intervention 3.1 in NSP: Optimize the administration of tuberculosis preventive treatment*		
3.3 Development of innovative and effective IEC materials and communication strategy on TB infection control and TB preventive treatment This should address their common concerns such as drug resistance, adverse events and durability of the protection in a clear manner. 1. Hire communication expert to develop communication strategy and tools 2. Produce the IEC materials *Sub intervention 3.1.4 in NSP: Improve effective prevention and promotion strategies for LTBI* *Sub intervention 3.2.4 in NSP: Conducting promotion and prevention through tuberculosis education to community*	Both TB infection control and TB preventive treatment are effective interventions but not easy to be advocated since the targets are non sick persons. Therefore, investment is needed in effective communication methods that can reach the target population, health workers, and service providers. JEMM 2020 advised that IEC material should be provided for both patients and health care workers. From total budget for this activity under NSP, domestic funding only covers limited of TB communication strategy development and cannot be allocated to engage professional communication experts or behavior change experts. The proposed intervention corresponds to **"Prevention"** intervention of the "**TB care and prevention"** module of the GF modular framework.	**$ 63,530.15**

NSP Strategic Area 4: **Utilization of the effectively proven technology of screening, diagnosis, and treatment**		
Intervention	Rationale for prioritization for Global Fund funding	Amount requested from the Global Fund
4.1 Set up a system to monitor available research results or researches being conducted to be in line with TB program needs and to adopt relevant approaches that improves TB program deliveries. 1. Coordinate research groups and the national institute of health research (Balitbangkes) to conduct TB researches needed by the TB program 2. Develop and update TB research agenda 3. Advocacy of open data platform to research institutions that conduct TB research 4. Annual national TB research conference 5. Annual international TB research conference (INA-TIME) *Intervention 4.2 in NSP: Develop a mechanism to direct Tuberculosis research in line with the agenda so it can be useful for the National Tuberculosis Program*	Research environment should be built to support TB program decide evidence based strategies. Existing structures are to be utilized and coordinated to ensure researches agenda follows the needs of TB program. NTP proposed activities to enable the coordination of different research bodies, including the one under the MoH, in conducting relevant TB researches and enable the TB program adopt the evidence resulted from those researches. The proposed intervention corresponds to **"Coordination and management of national disease control programs"** intervention of the "**Program Management"** and **"Analysis, evaluations, reviews and transparency"** intervention of the "**RSSH"** modules of the GF modular framework.	**$ 254,120.60**

4.2 Support the implementation of trials, operational and implementation research on new vaccines, drugs, or diagnostic tests in collaboration with existing global network - Annual discussion integrated in the annual conference to assign studies to research institutions in the network - Participation of international TB conference (i.e. Union Conference) *Sub intervention 4.4.4 in NSP: Encourage the holding of a national TB seminar every year as a forum for TB researchers to present the results of their research* *Sub intervention 4.4.5 in NSP: Encourage researchers to present the results of TB research at national or international scientific meetings*	Our proposition is to enable national TB program assign the studies on the pipelines intervention for rapid adoption to the program. The potential area of this trials are novel drugs regimen for TB/ DR-TB treatment and prevention, new rapid diagnostic test and TB vaccine. The proposed intervention corresponds to **"Analysis, evaluations, reviews and transparency"** intervention of the "**RSSH"** module of the GF modular framework.	**$ 291,179.86**
5.3 Conduct TB prevalence survey. This will be conducted by the MoH. WHO will provide technical assistance *Sub intervention 4.2.4 in NSP: Develop TB research agendas with network members and policy makers*	The ppopulation based survey is important to directly measure the TB burden, impact of TB control and the progress towards TB elimination target. The last NTPS was conducted in 2013, therefore it is time to repeat the survey in 2023 before 2025-2030 milestone evaluation periods. Without solid evidence and most recent data on TB burden and situations, NTP will have problem to understand their epidemy. To relay on 10 year old data of TB prevalence and 7 years old inventory study will raise unnecessary question to NTP, especially to advocate for sustaibility of funding for the next NSP periods which should rely on domestic fundings. MOH allocated a small amount of funds to the NIHRD for TB epidemiological data surveys, however the amount is not sufficient to fund a credible TB prevalence survey. WHO has possibility to mobilize resource to provide technical assistance supports for the survey. GF support is expected to cover operational support of the survey similar with 2013 NTPS. The proposed intervention corresponds to **"Survey"** intervention of the "**RSSH"** module of the GF modular framework.	**$ 3,709,181.39**
5.4 Conduct TB drug resistance survey. This will be conducted by the MoH. WHO will provide technical assistance *Sub intervention 4.2.4 in NSP: Develop TB research agendas with network members and policy makers*	The survey is important to measure the rate and trend of TB drug resistance and indirectly understand the progress made in Programmatic Management of Drug-Resistant TB. The coverage of rapid molecular test with Rifampicin resistance test is expected to reach 75% in 2024. Before that, and without routine DST beyond Rifampicin, drug resistance survey is needed. With the dynamic of new DRTB regimen that is not followed by the increased capacity of routine drug susceptibility test, a survey to test different drugs resistance is still relevant. The magnitude of DR-TB problem in	**$ 1,073,617.74**

	country need to be measured precisely and carefully since DR-TB control will occupy majority of domestic resources and sacrifice allocation for other TB interventions. NTP proposed to have DRS survey every 5 years and the last survey conducted in 2017. The results will correlated also with national DR-TB treatment policy. The proposed intervention corresponds to **"Survey"** intervention of the "**RSSH"** module of the GF modular framework.	
4.5 Conduct KAP survey to communities on TB and care seeking. This includes whether the care seeking is affected by stigma orgender andhuman right related barriers. This will be conducted by a selected research institution. WHO will provide technical assistance (will be requested through PAAR) *Sub intervention 4.1.2 in NSP: Evaluation of knowledge, attitude and practices on tuberculosis treatment behavior and its barriers*	There are no available data on current level of knowledge, attitude and practice of TB patients and community to guide NTP to design matched communication strategy and patient friendly treatment pathway. The last KAP data was only available from 2008 where TB Program was still focusing on primary care and no NHIS (national health insurance scheme) existed. It is important also to measure patients health seeking behavior after implementation of NHIS. The proposed intervention corresponds to **"Analysis, evaluations, reviews and transparency"** intervention of the "**RSSH"** module of the GF modular framework.	**$ 141,177.96** (PAAR)
4.6 Develop mobile apps to inform TB data that is easily accessible by public and district leaderships (will be requested through PAAR) *Intervention 4.1 in NSP. Utilizing digital technologies to support the implementation of the national TB control program*	The mobile apps will function like the WHO Global TB Report apps that public and district leaderships can have access to TB data in Indonesia until the district level	**$ 50,001.76** (PAAR)

NSP Strategic Area 5: **Improve community, partner, and multi sectoral participation in TB elimination**		
Intervention	Rationale for prioritization for Global Fund funding	Amount requested from the Global Fund
5.1 Improve capacity of community workers to sensitize civil society on TB elimination, including the awareness of human right and gender based barriers (training of trainers) *Sub intervention 5.1.1 in NSP: Increase communication, information, and education effort*	NTP aims to increase community demand on services by strengthening community knowledge and awareness on TB elimination modalities. The proposed intervention corresponds to **"Social mobilization, building community linkages and coordination"** intervention of the "**RSSH"** module of the GF modular framework.	**$ 26,271.70**
5.2 Initiate and maintain community movement on TB control: 1. Initiate district TB control team led by the district major and involved various elements of community 2. Initiate the creation of TB care communities (Kelompok Masyarakat Peduli TB) to facilitate various advocacies	Empowered communities are important to facilitate advocacy to different sectors and authorities, to provide feedback and demands on the service quality, and to provide feedback on barriers, stigma, and discrimination that hinder the access to TB care. The proposed intervention corresponds to **"Community-led advocacy and research"**	**$ 1,250,485.12**

to different sectors and authorities *Sub intervention 5.1.2 in NSP Involving public to prevent and control TBC*	intervention of the "**RSSH"** and **"Community mobilization and advocacy"** intervention of the "**RHRGRB"** modules of the GF modular framework.	
5.3 Implement community system to follow up treatment (TB, HIV, MDR TB, TPT) 1. Setting up treatment buddies with comprehensive responsibilities and familial approach (since we need to cover family members for TB screening and TPT) 2. Expand the work area of the buddies to the private providers 3. Empower survivors (ex patients) to be involved in the system 4. Results based rewards for community supporters 5. Develop National Community Health Worker strategy to ensure pre-service education, and deliver integrated HIV, TB and malaria services at community level 6. Shelters 7. Community DR-TB Case Managers 8. Training for case managers and patient supporters. Including the human right and gender sensitization to enable comprehensive support 9. Transport allowance for community cadre coordinators *Sub intervention 5.1.2 in NSP Involving public to prevent and control TBC* *Sub intervention 2.2.11 of NSP: Strengthen education and peer group in health care facilities since the drug-resistant confirmation to treatment completion by giving counseling to improve access to treatment and treatment adherence* *Sub intervention 2.2.13 of NSP: Strengthen the role of the community and former tuberculosis patients to improve treatment outcomes of drug-resistant Tuberculosis*	The long duration of treatment requires people with accompanying roles that support the patients and families to complete any treatment that they take. The roles of community interventions is enhanced to cover new function such as TPT screening and provision. The linkage of community with health facilities will be expanded to supports the private providers to improve the treatment quality. The roles of community should be formalized with clear structure and incentive to ensure high quality deliveries. There is a regulation barrier to chanell government funds to community/ CSOs, however some opportunities to have domestic funds for community service deliveries has raised through village funds and BOK. However the models and mechanism need to be built first and need to compete with other health intervention. NTP proposes to continue current community intervention before handling over to domestic funds. There is high possibility to develop and implement this approach jointly with HIV and malaria programs in overlapped priority districts. The proposed intervention corresponds to several **"Community service delivery"** interventions of the "**TB care and prevention"**, **"MDR-TB"** and "**RTB-HIV"** modules of the GF modular framework	**$ 7,447,812.63**
5.4.Implement community based monitoring feedback to strengthen the service quality of TB program *Intervention 5.3 in NSP. Improve the mechanism for public feedback on the tuberculosis services quality at the health facility*	CSO and TB survivor organization propose to set up a model of feedback from patients, community workers, community members, to improve TB service quality. The proven cost effective model is expected to be taken over by the government or other resources in the future. No funding is available from the domestic source The proposed intervention corresponds to **"Community-based monitoring"** intervention	**$ 42,353.43**

	of the "**RSSH"** and **"Community mobilization and advocacy"** intervention of the "**RHRGRB"** modules of the GF modular framework.	
5.5 Reduce stigma and discrimination faced TB patients 1. Human right sensitization session included in each training or education activity and IEC materialsespecially among health workers (training budget is included in different strategies) 2. Public campaign on "know your right" targeting policy makers who deal with the health rights of employees. 3. Monitoring and response to negative campaigns that have potential to create stigma and discrimination to TB patients and related stake holders 4. Paralegal recruitment and training. Basic and advance training is planned in 20 big cities with a lot of industries and daily workers. Eleven cities are overlapped with HIV and will be requested from the human right and gender barrier catalytic funding of human right that is requested under HIV program. The TB funding is requested to fund the activities in 9 cities 5. Collaborate with pro bono lawyers to defend discriminated TB/HIV patients. 6. Engagement of legislatives, relevant ministries, religious and community leaders to amend the Minister of Labour and Transmigration decree no 3/1982 concerning occupational health services and monitoring implementation of TB regulation 7. Peer mobilization and support developed for and by people with TB aimed at promoting well-being and human rights *Intervention 5.5 in NSP: Reduction of stigma and discrimination in high-risk tuberculosis populations and vulnerable populations*	TB patients faced the stigma and discrimination when they seek treatment (from health workers), receiving home visits (from community members who saw the health workers visit the house), and when they disclose that they have TB in their workplaces. The focus of our interventions are the health workers and workplaces. The PRs proposes comprehensive actions to reduce stigma and discrimination. The domestic funding is currently not available. Some elements are possible to be integrated with HIV program. The availability of rapid communication response to negative news and hoax in media or social media by recruitment of qualified communication team is very important. Many confirmed TB/ DR-TB cases (almost 25% in some setting) received wrong information during pre-treatment and treatment phase from social media then refused/declined standard treatment. This was also documented in JEMMM 2020 report. Proposed revision to the Minister of Labour decree was needed to include CXR and symptomatic TB screening in the medical check up package of the employees, so it will be legally bond and all employers will need to follow this. The proposed intervention corresponds to **"Human rights, medical ethics and legal literacy"**, **"Legal aid and services"** and **"Stigma and discrimination reduction"** interventions of the "**RHRGRB"** module of the GF modular framework.	**$ 295.763,34**
7.6 Coordination with related authorities to implement TB control among population with high risk of TB (dormitories, religius dormitories, immigrants, social houses, prison inmates, migrant workers, Haj participants) *Sub intervention 5.2.1.1 in NSP 5.2.1.1. Coordination with relevant ministries for TBC control in special places (dormitories, boarding schools, social institutions, immigrant shelters etc)*	The coordination with the authorities aim to develop and implement regulations on TB screening to the population under their jurisdiction. The advocacy is potential to bring various authorities to regulate and allocate their resources. The proposed intervention corresponds to **"Community-led advocacy and research"** intervention of the "**RSSH"** and **"Community mobilization and advocacy"** intervention of the "**RHRGRB"** modules of the GF modular framework.	**$ 21,176.72**
5.7 Coordinate district level networking of stakeholders: 1. Coordination with association of medical	To be effectively implement their roles, different stake holders in the district should be coordinated by the district health office. The	**$ 63,530.15**

professional 2. Coordination of TB patients and survivors association 3. Coordination of community based organization that support TB control *Sub intervention 5.1.2 in NSP Involving public to prevent and control TBC*	request is to enable the district health office organizing stakeholder coordination activities. The proposed intervention corresponds to **"Social mobilization, building community linkages and coordination"** intervention of the "**RSSH"** module of the GF modular framework.	

NSP Strategic Area 6:**Strengthen TB program management through health system strengthening**		
Intervention	Rationale for prioritization for Global Fund funding	Amount requested from the Global Fund
6.1 Enhanced priority districts capacity to manage increase workloads of TB key interventions , targets, and grant management by 1. adding human resources to fulfill needs of a project administrative management role; a technical officer role to coordinate/ oversight PPM, PMDT, TB-HIV and LTBI expansion; data officer responsible for collection and data quality assurance; and financial administrative role. (*the technical officer, data officer, and finance coordinator are proposed in strategy 1 budget*) 2. Human resource salary for grant management of PR, SR, and SSR in national, province, and district level 3. Office supports (PRs, SRs, SSRs) 4. External audit fees 5. Maintenance costs 6. Accountant supervisions 7. Procurement for new community SRs/SSRs 8. Capacity building for PRs staff	The basic management unit of GF supported activities are idealy established at district level. Current issues of grant implementation and target achievement are related with long line communication and coordination since the basic management unit is designed in the provincial level rather than district. The additional human resources will allow the district TB coordinator (district TB Wasor) to focus on strategic planning, implementation, monitoring, and evaluation of district action plans and coordinate different stake holders in TB control in the district. Current GOI human resource policy still focusing on fulfillment of strategic HR at health facilities (doctor, nurses and midwifes). JEMM 2020 recommended MOH to strengthen public health function for TB with sufficient staff. NTP proposes to fulfilled those function with GF supports and stepwisely handling over to district HR structures by 2023. The proposed intervention corresponds to "**Grant management"** intervention of the **"Program management"** module of the GF modular framework.	**$ 13,425,660.37**
6.2 Engage Province and District Human Resource Development Board (Bapelkes) to contribute to TB human resources capacity building and training: 1. Development of National HR Plan for TB 2. Needs assessment, planning and coordination of TB HRD at the provincial level 3. Training plan development at the provincial level that includes the allocation of human resources and the capacity buildingplan 4. Post training evaluation *Intervention 6.1 in NSP. Improving health*	JEMM 2020 identified that the ratio of active TB staffs is 1.15 per 10,000 population with 38% of those staffs are untrained due to high turn over rate.To streamline the human resource development plan with the appropriate institution under MoH at national, province/ district levels, NTP proposes activity to strengthen linkage with Bapelkes. The proposed intervention corresponds to "**HRH policy and governance"** intervention of the **"RSSH"** module of the GF modular framework.	**$ 921,254.94**

worker skills to treat and manage Tuberculosis program		
6.3 Undertaken major training for TB program officers and health care workers by: 1. Setting up innovative and effective training methods by developing internet based training, integrating human right and gender sensitization in the training 2. Training of trainers of comprehensive TB management in the province and national level (the training implementation for health workers have been requested in strategy 2, and the community workers in strategy 5) *Sub intervention 6.1.5 of NSP Conduct online training of Tuberculosis care and prevention by long-distance training program for private physicians* *Sub intervention 6.1.7 Training of trainers on tuberculosis care and prevention in primary and referral health facilities, laboratory, and training for tuberculosis program management for staff at national, provincial, and district level as well as for cadres*	The conventional training models may not cope with the training needs, NTP propose to revise TB training modality with innovative long distance trainings, multi media based tutorials, etc. in order to reduce financial and time burdens. The availability of pool of trainers from outside of NTP staffs structures is extremely needed. JEMM 2020 recommended MOH to support the health facilities staff to do their work. Their major training needs to be undertaken by the NTP, to significantly upskill both the public and private staff delivering TB services to patients. This training package must include communications skills, ways of addressing stigma against people with TB and HIV, and the importance of effectively passing on life-saving information to patients. NTP proposes training of trainers to fulfil the TB training demands up to provincial levels, since many of existing pools of trainers either inactive or need replacement. The proposed intervention corresponds to "**Education and production of new health workers"** intervention of the **"RSSH"** module of the GF modular framework.	**$ 835,492.06**
6.4 Enhanced, upgrade and expand the mobile application of TB case notification from private clinics or stand alone doctors to increase TB case notification. 1. System maintenance and upgrade 2. Mop up of TB cases notification in 180 districts *Sub intervention 6.2.1.1. in NSP: Develop and maintain cellular apps Wajib Notifikasi Tuberkulosis (WIFI TB) for private medical practices/clinics which is linked with SITB*	The lesson learnt from WIFI TB mobile application shows that the system works, however the implementation model and the complicated connectivity with SITT caused low data entry and low system utilization. The implementation needs to be evaluated and the application needs some upgrade on its interface and connectivity to SITB. The simple application with direct link to SITB will improve the case notification from the private providers. The system will facilitate NTP supervising the quality of TB services provided in those clinics. The proposed intervention corresponds to "**Engaging all care providers"** intervention of the **"TB care and prevention"** module and **"Routine data"** intervention of the **"RSSH"** module of the GF modular framework.	**$ 424,042.58**
6.5 Strengthen and maintain supporting information system for TB program: eTB- 12, TB-14, community activities related apps, and logistic system that link to SITB 1. System development and maintenance 2. Advocacy to big chain hospitals to develop link of information system 3. Integrate TB data collection software or programs from hospitals, Health insurance, Pusdatin (healh information department of MoH), and other ministries and institution with SITB	Strengthening of disease specific information system will improve the quality of data entry, validation, quality assurance, and utilization of information to inform policy and develop strategy for action. After the national SITB works well, the priority should be to enable linkage of SITB with the BPJS and hospital data records of TB cases, as well as improvement of routine surveillance. The current and temporary "mopping up" activities is considered late in driving real time monitoring and performance management. We	**$ 197,649.36**

4. Contribute to strengthen general health information system (ASDK) to link important TB indicators in the general system. *Sub intervention 6.2.1.2. in NSP. Develop and maintain supporting information system for tuberculosis program, i.e. e-TB-12, TB-14 and logistics which is linked to SITB*	propose to establish the link of SITB with civil registration data for unique ID number (own by MoHA) to have more accurate information on civil data, especially mortality. NTP will collaborate with Pusdatin to integrate SITB with ASDK to ensure that TB program performance indicators will be visible and be monitored closely by decision makers at each level. The proposed intervention corresponds to "**Engaging all care providers"** intervention of the **"TB care and prevention"** module and **"Program and data quality"** intervention of the **"RSSH"** module of the GF modular framework.	
6.6 Strengthen capacity of TB information system: 1. Investment on device or program 2. Training of human resource to use the information system *Sub intervention 6.2.2 in NSP: Investment on facilities and human resources*	JEMM 2020 recommended that The NTP must improve the reliability and consistency of the data it generates. The new SITB surveillance system will enhanced NTP capacity to improve quality of routine surveillance in order to replace the temporary "mopping up" activities. NTP proposes further investment on hardware, software and brainware to ensure SITB can fulfill all intended requirements. The investment also needed for capacity building of TB programmer and health facility TB officers, including for maintenance and troubleshooting. The proposed intervention corresponds to "**Program and data quality"** and **"Routine data"** interventions of the **"RSSH"** module of the GF modular framework.	**$ 2,093,620.57**
6.7 Conduct evaluation of TB program: 1. Development of annual TB report 2. Annual national and sub national level monitoring and evaluation 3. JEMM & Epidemiology Review 2023 *Sub intervention 6.2.3.1. in NSP: Supervision on data quality in all levels* *Sub intervention 6.2.3.5. in NSP: Implement program review* *Sub intervention 6.2.4.3. in NSP: Development of annual profile of National Tuberculosis Program*	NTP proposes to organize annual evaluation meeting and produce preports to enable tools/ media for all staffs and stake holders to share the achievement, challenge, and lessons learnt of their experiences and efforts. The independent program review at 2023 also proposed to provide NTP with independent and valid expert opinion on progress, challenge, achievements and recommendations for way forward. The proposed intervention corresponds to "**Analysis, evaluations, reviews and transparency"** intervention of the **"RSSH"** module of the GF modular framework.	**$ 1,463,180.15**
6.8 Explore national financing system for future TB program financing 1. Develop a system to track TB program expenditures from different sources of financing, including the central and sub national government, the national social health insurance (JKN), and other sources such as hoseholds (OOP) and the private sector. Stronger emphasis for the tracking will be given to capture province and district budget allocation and expenditures, and JKN program expenses for all TB related services. The system will include	In the absence of a comprehensive picture of TB financing, especially with limited financing data from the sub national levels and JKN program, it is difficult to have an efficient planning. A full understanding on how the program is currently being financed, and how the money is used will be key to improve both allocative and technical efficiency, and also in the end improve sustainability of the program. Advocacy and coordination is needed for future budget allocation of TB control, conducted in every starting of fiscal year planning. The highly anticipated presidential regulation will increase domestic funding allocation for TB. To ensure	**$ 52,235.90**

program expenditure tracking/budget tagging, or regular TB spending assessment (similar to NASA), or Disease Specific Health Account (a derivate of NHA/DHA exercise) 2. Advocacy to increase budget proportion for TB control from inter-ministerial budgets and sub-national levels, in collaboration with ministry of planning and ministry of finance. This will be integrated with coordination meeting with related ministers for the agenda in strategy 1 3. Advocacy to the Ministry of finance to increasedomestic fundings for capacity building activities, including from health facility. *Intervention 6.3 in NSP. Strengthening financial system for Tuberculosis*	that momentum, NTP request budget from GF to initiate advocacy activities for sustainable fundings. The proposed intervention corresponds to "**Health financing sustainability"** intervention of the **"RSSH"** module of the GF modular framework.	
6.9 Strengthen procurement and supply chain management effectiveness, in colaboration with Malaria and HIV program: 1. Develop district logistic team 2. Logistic coordination meeting with different program managers in district health office 3. Mapping logistic resource 4. Set up logistic procurement system per level of health office 5. Set up and implement logistic SOP 6. Logistic training 7. Logistic monitoring and evaluation in all level 8. Technical assistance to enhance local drug manufactures to produce new TB drugs domestically. 9. PSM handling costs Intervention 6.4 in NSP. Strengthen logistic management system for Tuberculosis	NTP proposes to strengthen the logistic and pharmacy team in each level (central, province, district, and health facilities) to streamline TB commodities management into the existing logistic system of MoH, provincial, and district health offices. This activities will be integrated with the Malaria and HIV program and the budget will be managed by malaria/HIV program The proposed intervention corresponds to "**Policy, strategy, governance"**, **"Procurement capacity"**, "**Regulatory/quality assurance support**" and "**Storage and distribution capacity**" interventions of the **"RSSH"** module of the GF modular framework.	**$ 6,466,139.51** **PSM handling cost for PAAR health products: 4,468,747.03**

(Add additional tables as relevant)

TOTAL AMOUNT requested from the Global Fund (including matching fund and PAAR; PAAR will be explained in detail in the PAAR sheet)	**Total : $ 246,451,577.81** **Allocation: $ 150,447,024.45** **Matching fund: $ 9,999,978.68** **PAAR: $ 86,004,573.68**

Explain the prioritization approach used to select interventions for Global Fund funding.

Indonesia aims to dramatically reduce tuberculosis incidence to 65/100,000 by 2030 from 316/100,000 at 2018. To achieve this target, National TB Program will significantly increase TB case notification to 90%

estimated incidence, improve treatment success rate to above 90% and expand TB prevention provision to household contacts by end of 2023. We take into account the JEMM 2020 recommendations and the stake holder recommendations during modular and consultative meetings. In this proposal, the interventions for Global Fund funding were selected based on:

1. Priority activities from National Strategic Plan 2020-2023 with direct measurable impact to the TB epidemic. The general approach is based on the calculated impact to reduce TB incidence in the required speed to achieve TB elimination. Therefore we prioritize funding for implementation of activities and strengthen TB platform at high estimated incidence districts.
2. The prioritized interventions directly linked to targeted outcomes:
    a. Increase TB case notification with intensified case finding, active screening at community and health facilities, community contact investigation, and enforcing the implementation of mandatory notification
    b. Increase DRTB enrollment by service decentralization, enablers provision, health workers incentives
    c. Increase HIV testing coverage among TB patient and provision of ART for TB-HIV co-infected.
    d. Increase the coverage of TB preventive treatment among household contacts, PLHIV, and people with immunosuppresed condition.
    e. Improving treatment quality of DS-TB and DR-TB patients equally both public and private providers.
3. Priority interventions with financial gaps that have potential to be taken over by the domestic resources in the future:
    a. Strengthen PPM platform at district level through advocacy and effective engagement of Ministries, National Health Insurance (BPJS), private health providers association, professional organization district governments
    b. Human resources to improve program effectiveness, as an example for future taking over by the district government. This is the argument to propose additional district team.
    c. DR-TB service and TB laboratory capacity expansion
4. Intervention to reduce barriers to care, such as stigma and discrimination, advocacy to enable social protection for TB patients
5. Innovated approach that can be implemented by community actors to improve TB program effectiveness
6. Interventions that are important but the government have very limited fiscal capacity to supports such as technical assistance, program review and important epidemiological studies/surveys to measure progress for better control program.

More than 50% allocation fund is requested for TB specific intervention in high priority districts with more than 87% of estimated TB incident cases. In the NSP 2020-2024, NTP proposed **334** districts as TB priority districts, consists of 292 TB high burden districts and 42 low TB burden but high HIV burden districts. These 334 districts are spread over 34 provinces. We prioritize the intervention by districts because the district government has autonomy to decide the TB action plans and the resource mobilization for their districts. As TB is widely distributed in all population in Indonesia, the number of priority districts are high, as the selection is based on the estimated TB incidence in the area (> 1000 cases per year). We consider that covering 87% of estimated TB burden will be an effective strategy of prioritization.

The NSP priority interventions proposed under this FR are selected by NTP, TB affected groups, communities and CSOs representatives, existing PRs and development partners, under coordination and leaderships of CCM Indonesia

The activities that we can secure or expect to secure funding from the domestic fund is not requested here, such as part of first line and second line drugs, diagnostic test, part of human resource training, part of coordination meeting and supervision.

b)If an aspect (or the entirety) of this funding request uses thePayment for Resultsmodality:

Use the table below to list and provide the rationale for selection of the **proposed performance indicators or milestones** for Global Fund funding.

Performance indicator or milestone	Target				Rationale for selection of the indicator/milestone
	Baseline	Y1	Y2	Y3	
Add rows as relevant					
TOTAL AMOUNT requested from the Global Fund					

Specify how the accuracy and reliability of the reported results will be ensured.

[Applicant response]

Explain the prioritization approach used to select performance indicators and/or milestones as results for Global Fund funding.

[Applicant response]

c) Opportunities for integration: explain how the proposed investments take into consideration:

- Needs across the three diseases and other related health programs;
- Links with the broader health systems to improve disease outcomes,efficiency and program sustainability.

Proposed integrated approach:

1. The Tuberculosis program main coordination platform with the HIV and Malaria program lies in integrated disease data management (SITB, SIHA, SISMAL) via the MOH's Center for Data and Information (Pusdatin) data system for health and in the involvement of the Ministry of Home Affairs (MOHA). The Center for Data and Information allows for high-level tracking of progress, while the Ministry of Home Affairs has the ability to monitor and evaluate district and provincial performances against minimum service standards (SPM) deliverables. The three programs (TB, HIV, and malaria) will support Pusdatin to strengthen the linkage of each program database using the official unique identification number (NIK)
2. In strengthening health information system, disease specific information system which contains detailed information from three diseases will be linked to national dashboard data for health. The general health information system (ASDK) will be capacitated to extract important TB indicators. The contribution of TB program will improve ASDK dashboard to be accessed by regional leaders (national, province, district). TB program will contribute aggregate data to the ASDK managed by Pusdatin
3. Tuberculosis program cooperates with Indonesia's centralized procurement and logistics system, which serves all disease programs in the country. Joint capacity building for logistic and pharmacy warehouse staffs in district, provincial, and national level to manage the drugs and supplies of the 3 diseases are feasible. The cost shared among the 3 programs will follow the priority districts and provinces of each programs
4. Tuberculosis, HIV and Malaria programs will jointly strengthen Bapelkes in managing and conducting human resource training for different disease control interventions.
5. Tuberculosis and HIV program joint linkage with the maternal health and child health programs for TB and HIV care and prevention among neonatals, children under 5 and pregnant women can be developed and implemented mainly at primary care. Integration of TB screening and surveillance into RMNCAH surveillance system will be envisaged, especially in high TB burden districts.
6. Coordination with National Health Insurance (BPJS), hospital accreditation committee, laboratory accreditation committee to strengthen district PPM platform and synchronize/harmonize referral

system and its relevant equipments for TB-HIV services.

7. NTP works with Public Health Laboratories network for support of a variety of initiatives, including quality assurance of TB laboratory, anti TB drugs resistance surveillance, thereby leveraging internal MOH capacity to maintain and improrove TB laboratories quality.
8. Integrated advocacy with HIV program in removing barriers to access for treatment, prevention and care. In the overlapped HIV and TB priority districts, the activities related to removing human right and gender barrier can be combined. TB community proposed legal supportfor discriminated staffs paralegal training in 20 high burden cities with huge industrial activities. Among those 11 are overlapped with HIV priority districts, so the activities can be combined.
9. Integrated community supports, NTP works closely with two linked umbrella initiatives put forth by the MOH: Healthy Indonesian Families (PIS-PK) and the Healthy Communities Initiative (Germas), which aiming to establish link TB program with beneficiaries: families and communities. Use of *PKK* or *kader KB* to provide treatment observation support for 3 diseases in overlapped districts. In high endemic malaria districts, malaria volunteer will also conduct TB screening during home visit.
10. In the management of TB-HIV co-infected patients, HIV program ensure the provision of HIV tests while the TB program ensure the accessibility of rapid molecular testing for presumptive TB among PLHIV. The anti retroviral will be procured by HIV program and the TB drugs and TB preventive treatment will be provided by the TB program. In the overlapped TB-HIV priority districts, coordination meetings and data validation will be supported by HIV program, while in the TB priority districts, it will be supported by TB program. TB community supporters will support patients until getting HIV test and accompany the HIV-TB positive patients until enrollment to HIV program. The ARV follow up will be conducted by the HIV volunteers. HIV volunteers will support the uptake of TPT among PLHIV, while TB volunteers will support the uptake of TPTamong household contacts. HIV priority districts are divided into comprehensive, medium, and basic districts. In the overlapped high TB burdened and HIV comprehensive and medium districts, the health center staffs training to conduct HIV test will be supported by HIV resource. In high TB burdened and HIV basic districts, the HIV testing training in TB services will be supported by the TB resource.

d) Summarizehow the funding request complies with the **application focus requirements** specified in the allocation letter.

More than 50% allocation fund is requested for TB specific intervention in high priority districts with more than 87% of estimated TB incident cases. NTP proposed **334** districts as TB priority districts, consists of 292 TB high burden districts and 42 low TB burden but high HIV burden districts.
About 84% of the requested fund will cover the high impact intervention led to the decrease of incidence such as TB case finding, improve MDR-TB enrollment, scaling up TB preventive treatment.

# Districts	Proportion of TB Burden	Intervention	Percentage of Allocation
292 (estimated TB incident cases > 1000 per district,TB-HIV comprehensive area, PMDT priority area)	87%	**Comprehensive Intervention:** Strengthen PPM intervention, TB case finding at primary care and all public and private hospital, establishment of basic or enhanced MDR-TB service (**minimum 1 PMDT hospitals and all Puskesmas as treatment satelites**), **scale-up of TB preventive treatment for household contacts**, **enhanced** access to molecular testing. **Community and health service based active case finding.** **Note**: these 292 TB priority districts here are overlapped with 192 HIV priority districts and also 118 PMDT priority districts. It is estimated that 3,825,980 diabetes patients live in these districts	65.4%
222 (estimated TB incident ases < 1000 per district)	13%	***Essential Intervention:*** Basic PPM intervention, TB case finding at primary care and public hospital, establishment of basic MDR-TB service (1 PMDT hospitals and selected Puskesmas satelites), **initiation of TB preventive treatment for U5Y, basic access to molecular testing.** **Note**: even with low TB burden, *42 district out of 222 districts in this group are included as TB priority intervention districts since these districts considering as HIV priority districts (comprehensive/ medium).*	34.5%

Our request is aligned with the country priorities explained in the NSP. We propose high investment in health and community system:

1. Bring access to TB care closer to the patients by decentralizing diagnostic and MDR TB service
2. Support underlying system, such as
    - laboratory renovation to reach the appropriate biosafety levels necessary to conduct culture and DST procedure. This will contribute to the quality of tests of other diseases
    - Integrating specific disease procurement into the main MoH procurement and supply chain system
    - Strengthening TB information system with linking it to laboratory, hospital, health insurance, other diseases information systems and civil registration system
    - Important proportion of requested funding will be allocated to strengthen the district health offices and the district government, allowing more efficient utilization of existing human resources, sustained ownership and management efficiency, and engaging more domestic resources for health

We realize the importance of addressing human right and gender barriers. Comprehensive action in removing human right and gender barriers are planned under the allocation (integrating human right, stigma, and discrimination subjects in the human resource training and community education) and under the catalytic funding to set up legal support system for stigmatized and discriminated TB patients (through the HIV funding request).
If the proposed coordination and advocacy activities are implemented as planned, this will lead to the increase of domestic funding from different source:

- The increase of participation and premium of National Health Insurance. With more efficient management, the support for care and treatment will augment.
- The increase of the district government budget with support from the MoHA in putting standards on TB notification achievement. Some initiatives such as Zero TB city will provide examples of district level investment and will stimulate other districts to allocate resource to achieve TB elimination.

In our NSP, we estimate the increase of government funding to pay for staffs and diagnostic tests after the

issue of the Presidential Instruction.

e) Explain how this funding request reflects **value for money**, including examples of improvement in value for money compared to the current allocation period. To respond, refer to the Instructions for the aspects of value for money that should be considered.

We focus the proposed interventions on those with big impact on case notification, treatment coverage, and TB prevention that leads to faster decrease of incidence. High proportion of requested funding is directed for service provision. We propose better coverage of intervention and higher amont of funding for developing the policies and support system compared to the previous cycle. In this funding we request 15.12 million USD for RSSH component while in the previous cycle, we proposed 10.72 million USD.

Economy

All procurement for non-registered products (drugs, supplies) is via pooled procurement mechanism to ensure that the lowest global prices are paid for all commodities. Efficiency is attained via integration with Indonesia's health system, which ensures sustainability, the domestic procurement of inputs (drugs, supplies) follows the policy of the Ministry of Health that is continuously audited. The decision on procurement is based on e-procurement (e-catalogue) mechanism of GoI. If this is not applicable then the lowest cost proposed by the candidates of vendors in the bidding is obtained while ensuring the required quality and quantity. Interventions supported are those recommended by WHO and are thus based upon the best evidence available.

The proposed additional human resources that will be funded from this cycle are to strengthen the program management in the high burden districts.

To reduce the cost setting up new intervention, some activities are prepared to be piloted or implemented in 2020, such as:

1. Complete the preparation of 260 district hospitals to provide DR-TB services according to the Minister of Health decree
2. Piloting active case finding by particular initiative, such as the TB Reach Projects. This will provide lessons learnt on the cost, challenges, and how to optimize the roles of different stake holders
3. Piloting the algorithm that integrate contact investigation, TB diagnostic, and TB preventive treatment. This will provide lessons learnt on the cost incured, especially on the extended indication TB preventive treatment to all household contact and the use of TB infection test and CXR to decide TB preventive treatment. It provides lessons learnt on the system, such as data collection, delegation of tasks, coordination under Puskesmas
4. Piloting the CBMF
5. Piloting the sputum transportation system, under the project SITRUSS

Efficiency

Bold policy and supportive system will be required to maximize output, outcome, and impact of our interventions. Therefore important proportion (7%) of our requested funding will be allocated to

- strengthen district health management team (system level efficiency cannot be fully realized without managerial efficiency and effectiveness at the sub-national levels) ,
- advocacy to the national insurance system to harmonize the financing system to the necessary care and referral system (appropriate strategic purchasing arrangements for TB will improve TB service quality, ensure cost controls, motivate providers to retain and refer people to the correct level of care, and avoid over- or under-use or inappropriate use of TB services) .
- advocacy and collaboration in developing and harmonizing regulations inside the MoH and of the other ministries
- strengthening community system (community members will contribute to improving the delivery of care through the alignment and harmonizing of the processes of the different services)

The disease specific intervention that we proposed can not be implemented to reach our expected goals without the structural and systematic support of regulations and governance.

On technical side, allocating resources to preventing active TB among high-risks adults and children combined with early diagnosis and treatment of active TB and DR-TB cases, including improved treatment uptake and treatment outcome, especially for DR-TB are critical to be prioritized and later can save million treatment outcome can prevent transmission. Completing treatment for LTBI can reduce the risk of TB disease substantiallyInvesting on diagnostics, intensified and active case finding is also considered the best use of resources (allocative efficiency) as it will lead to early diagnosis and treatment of TB patients and

eventually will have an impact on the reduction of TB burden in Indonesia.

Equity
Our proposed interventions address different barriers that are faced by TB patients to access the care. We plan to decentralize more the MDR TB and TB HIV services, additional number of culture and DST laboratories and strengthen sputum transportation system to overcome geographical barriers. We propose enablers for MDR TB patients to overcome the lost of income and the other opportunity cost caused by the disease. We propose legal support to overcome stigma and discrimination faced by the patients, on the top of sensitizing communities and health workers on those issues. The TB case finding activities will be directed to the population with high risk of TB, which are often the vulnerable and marginalized population such as poor communities, prison inmates, elderly, and children.

2.3 Matching Funds (if applicable)

This question should only be answered by applicants with designated matching funds, as indicated in the allocation letter.

Describe how the **programmatic and financial conditions**, as outlined in the allocation letter, have been met.

We propose the matching funding to finance the two types of activities:
1. activities of finding missing cases to complete the NSP targets. We propose to conduct TB case finding in non TB services in hospitals and primary health centers (intervention 2.1). 2. Engaging community health workers to visit patients who do not come to get TB treatment in the appointed date in private hospitals to improve the treatment success rate in private sector.

Rational and proposed activities under catalytic funding
The TB screening on DM patients is considered a priority for matching fund at this time because the burden of DM is very high. The burden of diabetes costed the third highest DALYs in Indonesia in 2017. In Indonesia, the prevalence of diabetes is estimated to be 1.5%, with the highest percentage among the group of 55-75 years old (National Health Survey 2018). The prevalence of TB is also the highest among this group (TB prevalence survey 2013-2014)It is estimated that DM contributed to 25,000 TB cases.
The TB screening on diabetes on non communicable disease patients is mentioned in the NSP 2020-2024 as specific intervention.
The funding for this activity will be invested not only to gain more TB cases, but also to strengthen bidirectional screening structures that will lead to sustainable interventions.

To target the elderly population, the NTP and the diabetes subdirectorate to implement bidirectional screening among TB and DM patients. The elderly population usually visit internal medicine, DM, or elderly clinics, where the TB screening will be implemented. However, CXR screening is not covered by the national insurance, unless there is already a respiratory problem (medical indication). Therefore, a high proportion of the matching fund is proposed to conduct CXR among DM patients who do not present specific TB symptoms, while for those who already have respiratory symptoms will becovered by the national insurance or may not need CXR.
Finding TB cases among children and pregnant women activities will be continued in MCH services in hospitals, primary health centers, and community clinics (Posyandu).
From the comprehensive screening, we expect to detect about 25,000 TB patients from different services, including 8,000 TB-DM patients from CXR screening among DM patients

In 190 districts where community TB organization exists, in 2019, there were 74,886 TB patients are followed in private sectors. The baseline treatment success rate of private patients in 2018 was 38%. In 2021-2023, we expect about 550,000 TB patients followed in private sectors in the 190 districts. Assuming that 50% of patients will face episodes of missing the appointment, we plan to engage the community workers to conduct home visit to bring back the patients to finish the treatment. We plan to increase the treatment success rate in private sector to 90%.

The proposed activities for catalytic funding:

Activity 1	Budget 2021-2023 (USD)

Train 2 DHO staff health workers and 2 health workers in primary health centers (Puskesmas) in primary health centers (Puskesmas) in 334 districts to conduct integrated TB screening in PLHIV, DM patients, patients with immunosuppressed condition, pregnant women, people with mental health, and smokers	1,196,005.05
Train 5 health workers in 334 hospitals for intensified TB screening at non TB clinics.	239,068.19
Cross program coordination meetings at district level	495,111.64
Comprehesive screening in the above mentioned services, including CXR screening for 405,220diabetic patients per year	6,435,868.93
Activity 2	
Home visit by community health workers to the private patients who miss the appointment to get treatment for more than 3 days. We assume, 50% of notified TB patients in the private sector will need to get 1.5 visits	1,439,988.50
Biannual coordination meeting between PPM technical officer, CSO, and private facilities representatives in 190 districts	193,936.37
Total	9,999,978.68

Financial Condition

The allocation fund related to finding missing cases is proposed in the activities below:

1. Active case finding with CXR screening and rapid molecular test to prison inmates. The proposed budget is 3,176,507.51 (intervention 2.2)
2. Intensify household contact investigation (intervention 2.3) The proposed allocation budget is 6,816,492.50 and the PAAR budget for CXR screening to above 5 year household contacts in 25 highest burden cities is 1,059,037.02
3. Strengthen district PPM to enable TB notification from all providers (intervention 2.16). The proposed allocation budget is 683,511.00
4. Strengthen sputum transportation system: 1,331,083.71
5. Adding GeneXpert to the primary health centers: 5,640,951.10
6. Procure GeneXpert cartridge: 4,815,169.26
7. Strengthen mobile reporting system and connectivity to the TB information system: 109,568.33

The total budget of the finding missing cases activities in the allocation is 22,573,283.41 USD, exceeding 10,000,000 USD.

In the previous funding cycle, the budget for finding missing cases was 9,624,380.33 USD without the catalytic funding, for procurement of GeneXpert machines, cartridge, and screening activities in prison .

Catalytic funding implementation in the 2018-2020 cycle

In the funding cycle of 2018-2020, the matching fund has been used for two activities:

1. finding missing cases in the private sectors through the engagement of coalition of medical professional organizations (KOPI TB) and district public private partnership (DPPM) teams in 37 districts. Coordination meetings and training on WIFI TB and SITRUS were conducted. The mopping up of TB cases in private and public hospitals resulted in significant addition of notified TB cases. This approach will be continued with slight modification of DPPM approach where an engaged staff in priority districts will coordinate the DPPM efforts (see NSP, thematic intervention, PPM). The mopping up was considered temporary solution. We plan to scale up the use of WIFI TB and the link to SITT. These activities are planned under the allocation budget
2. Active screening on high risk groups. The catalytic funding on 2018-2020 was used to finance the procurement of additional Xpert MTB/RIF machines and cartridge, strengthen specimen transportation system, community based contact tracing and active screening of elderly, health facility screening for diabetes, elderly, and children. Those activities (cartridge procurement, specimen transportation, contact tracing) are planned under the allocation budget of this proposal. For this proposal, we propose to focus the matching fund to conduct systematic screening among the same target population but investing more on the screening modalities. We add CXR for those who do not present TB symptoms to increase the detection. The target we propose in this proposal is much higher than the previous catalytic funding proposal.

Section 3: Operationalization and Implementation Arrangements

To respond to the questions below, refer to the *Instructions,* NSPs and an updated **Implementation Arrangement Map(s)**[3].

a) Describe how the proposed **implementation arrangements** will ensure efficient program delivery.

In the implementation arrangement for the TB program supported by the Global Fund, there are six major strategies aligned with the NSP as specified in section 2.2, above. These strategies will be implemented by the MOH in cooperation with other relevant government ministries as well as with WHO, UNDP, USAID, DFAT, STPI, NGOs, and the private sector at the central, provincial, and district levels. The overall framework includes elements of finance, logistics, information systems, operational research to inform program policy and implementation, service delivery, health promotion, and community empowerment, with each element strengthened via good planning, implementation, monitoring and evaluation.

Indonesia's GF grant will be managed by at least two Principal Recipients (PRs), with the first being the Ministry of Health, implemented by the Directorate of Prevention and Communicable Disease Control via the National Tuberculosis Program. The other PR will be a Non Government Organization or a civil society organization to be selected by the CCM based upon competence and capacity to strengthen community-based tuberculosis control via support for advocacy, service deliveries and community empowerment.

The implementation area for the PR MOH will cover 34 provinces. Each of these 34 provincial health offices will serve as provincial SRs. The PR MOH will recruit relevant government institution, professional organizations and providers associations as needed to improve services in the private sector.

To enable the proposed structure to function, we propose the district health office of the 334 priority districts as Sub Sub Recipient (SSR), instead of implementing unit. With the district health office as SSR, project management will be more directly linked to the implementation, thus simplify and reduce the delay of fund transfer, reporting, and accountability process.
To enable the district health office serve as SSR, we propose the new district team composition, with a project management, a technical officer, a data officer, and a financial assistant in the 334 high burden districts. In the current funding cycle, the flow of decision and funding from SR (province) to districts as implementing unit contributes to implementation and reporting delay. We estimate that our proposed structures will overcome those delays because of more efficient implementation, control and coordination. The proposed structure allows direct progress monitoring and achievement of targets up to district level, also reducing gaps between project management and beneficiaries. The district team will be accountable for program performance and grant management at district level.

In the current grant, the management of PR with many SRs was thought to be beyond the program ability. In this proposal, we reduce the number of non provincial SRs and change the status of some previous SR into implementing agencies based on the volume of workplan to gain efficiency and better control. The PRs will set up risk based supervision system from PR to SR and risk mitigation SOP. The PRs, SRs, and SSRs in national, provincial, and district level will conduct quarterly meeting to validate data of activities, discuss and resolve commen challenge. In each meeting, the note for record and action plans will be written and followed up. This is the new approach that we propose to mitigate the coordination problem of the current grant implemetation

To cover the implementation of the planned activities, the SRs or the implementing agencies of the MoH PR will be:

a. Ministry of Home Affair to take the role of SR as they have the authorities and responsibilities to monitor the district government achieving the minimum service standards.
b. Dirjen Yankes (Directorate General of Health Services of the MoH), under which the

[3]An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage.

directorate of quality and accreditation will enforce TB standards for health facility accreditation and coordinate the engagement of health service providers to TB control activities

c. Dirjen Pemasyarakatan (Directorate General of Correction and Rehabilitation of the Ministry of Law and Human Rights) to take care TB and HIV case finding and care in prisons
d. Hospital associations, public and private to enable putting TB standards of care in the hospitals under their authorities
e. Associations or institutions which conduct TB active case finding
f. Medical professional associations to reinforce the implementation of updated evidence based recommendation of TB diagnosis, care, and treatment by their professional members
g. National institute of health research and development, to conduct TB prevalence surveys and TB drug resistence survey
h. Technical assistance providers.

The community PR will work closely with the PR MOH for the roles described in section 3(b): advocacy, service deliveries, community empowerment, behavior change communication, and removing access, human right and gender barriers. The community PR's activities will be prioritized in 190 selected high burdened TB, HIV, and DR-TB districts. In the other district not managed by the community PR, the district health office and Puskesmas will coordinate the local community health workers. The community PR will recruit SRs with special expertise as needed:

a. Community based organizations which capable to conduct/ coordinate contact investigation, active case finding, and patient's support
b. Community based organizations which work on advocacy and local CSO capacity building
c. Legal association to organize activities related to legal and human right related barriers
d. TB survivors organization that can conduct patients support and education

Enabler for MDR TB patients is proposed in the allocation. In the current arrangement, the transfer of money from the SR in provinces to the district implementer and the patients was challenging. In the current workplan of GF implementation, the enabler transfer system is being tested and set up. We expect to have the system ready for implementation in 2021.

b) Describe the role that **community-based organizations** will play under the implementation arrangements.

The community-based organizations who will get funding from GF will be responsible to implement the roles below:

1. Community system strengthening. The community PR will coordinate and strengthen local organizations or communities and TB survivors. The local actors are to be prepared to participate in advocacy movement, provide feed back on the TB service quality, treatment support, intensified case finding, and legal support against stigma and discrimination
2. Setting up community based feedback mechanism, following most effective models that is being tested currently.
3. Support contact investigation and community-based active case findings. The Puskesmas will coordinate community cadres for household contact investigations and the community PR will coordinate community cadres for close (non household) contact investigation. Community will continue to implement active case finding through symptomatic TB screening among community members and advocate for seek quality care and treatment.
4. Treatment support of TB patients, DR-TB patients, and TB-HIV patients:
    - Prepare and organize treatment supporter for TB treatment and the TB preventive treatment taken by the household contacts, PLHIV, and people with suppressed immunity
    - Community cadre will support diagnosed DR-TB patients until enrollment to treatment, then the TB survivor cadres will support the patient until treatment completion
    - Community cadre will be responsible to ensure all TB patients are tested for HIV. With the patient's consent, support can be continued for TB-HIV patients until ARV starts.

- Conduct home visit for the patients from private sectors who miss the treatment appointment to prevent lost to follow up and improve treatment outcome

5. Led community-based advocacy and resource mobilization for TB patients social supports and social protections.
6. Participate in paralegal's training to enable legal support for stigmatized and discriminated patients.

Activities carried out by community-based organizations will be coordinated with the government with 'bottom-up' scheme, beginning at community level with village leaders, community cadre coordinators with Puskesmas, district community initiatives with DHO and PHO up to national coordination mechanism between CBOs representative with MOH and other related ministries. CBOs will serve as important intermediaries whereby feedback from communities to the government can be provided such that the aspirations of the community are effectively delivered through CBMF platform.

In the implementation of the GF grant, the MoH PR and community PR implement different but complementary roles. The common aim is to achieve the targets set in NSP with the capacity of each other. In each level, information sharing mechanism is developed through regular validation meeting. In primary care level, the referral from community cadres and the outcome will be compared with the presumptive TB cases register and patient register. In district level, DHO and community SSR validate the target achievement data quarterly, then discuss the challenge and propose solution. In provincial level, both MoH SR and community SR ensure the validation of information and the communication process in their SSR follows the agreed mechanism. They should also provide technical support if any problem arised by their SSRs. Finally, in the national level, the two PRs coordinate quarterly to validate target achievement, discuss and resolve any problem affecting each other performance.

c) Describe key,**anticipated implementation risks** that might negatively affect (i) the delivery of the program objectives supported by the Global Fund and/or (ii) the broader health system. Then, describe the mitigation measures that address these risks, and which entity would be responsible for these mitigation measures.

Key Implementation Risks	Corresponding Mitigation Measures	Entity Responsible
Program quality		
The provincial and district government do not prioritize the TB control and elimination issue. The district action plans are failed to set up or the local funding mobilization is not sufficient	Government system: 1. MoH to ensure the implementation of Presidential Regulation 2. MoH to coordinate with the Coordinating Minister for Human Development to enforce the implementation in the other ministries. 3. Accountability of program at the district will be monitored by MoHA under monitoring system of SPM and regularly reported to the President. 4. Feedback mechanism will be strengthened through governance oversight mechanism from central government to province/districts by MoHA cq DG of Regional Development. Grant Management: 1. The PRs to implement of risk-based supervision regularly from PR to SRs and SR to SSRs. 2. The PRs to revise and disseminate PIM (project implementation manual) to the SR, partners, SSR,to improve knowledge and commitment in implementing TB program. 3. PR to link budget allocation and transfer of funds with the SR and SSR performance. Possible termination" should be the final option	MoH MoHA PRs
New PR can not immediately kick off operation in the beginning of 2021 because they need to form the structures and organizations with the SRs and SSRs	1. The district health offices to start engaging local TB CSO for further implementation of activities 2. The new PR to recover the district and provincial structures of the old PR 3. The new PR to coordinate closely with the Ministry of Health, PHO, and DHO in 2020 4. The new PR to prepare implementation in 2020 by coordinating with the SR and SSR structures of the old PR and decide the future arrangement	PRs DHO PHO MoH
Slow increase of notification from private providers and other non NTP provider. Current portion of the private sector and non NTP providers TB case notification was obtained from mopping up.	The notification from private and other non NTP depends on the efective coordination in central level with related ministries (non MoH hospitals), medical profesional association, and private chaines and the compatibility of data collection tools. The mitigation steps are: 1. NTP and Dirjen P2P to coordinate with BPJS in the BPJS supported health facilities to obtain TB notification data 2. NTP and Dirjen Yankes to coordinate with big chain private hospitals to allow access for	NTP and Directorate General of CDC (Dirjen P2P)

	taking the TB notification data 3. Dirjen P2P will coordinate with Ditjen Yankes to put the TB case notification as a requirement for hospital licence and accreditation. The Permenkes 67 on mandatory notification will oblige all departments under MoH to support its implementation 4. NTP will continue the mopping up with focus on hospital without electronic integrated information system. The mop up exercise is a short-term. The mid and long-term direction is to engage the unengaged providers (public and private) and align the reporting systems (SITT/SITB, hospital electronic system and BPJS).	
Slow scale up of TB preventive treatment. The current coverage of TB preventive treatment is very small in comparison with the ambitious target.	MoH to prepare the scaling up of TB preventive treatment since 2020. This includes 1. Conduct heath facility need assessment and mapping for implementation. 2. Put TPT as key indicators for program performance. 3. NTP to invest on effective IEC strategies to inform the population on TB preventive treatment issue. 4. The DHO and puskesmas to build the capacity of community cadres to support symptom screening and TPT observation 5. Piloting the link of contact investigation to CXR screening in active case finding Comprehensive piloting projects will be implemented this year supported by TB Reach.	NTP PR community DHO and Puskesmas
Slow scale up of HIV testing and ARV enrollment	- NTP to organize HIV test training for the staffs working in TB services in the puskesmas and hospitals (R1-R3) - The community PR will build the capacity of the community cadres to support TB patients until HIV testing is done - The DHO to implement and monitor the TB-HIV service linkage - The DHO to set up coordination meeting in their district to ensure linkage of referral and accurate data on co-infected cases	NTP, in collaboration with NAP PR community
Slow scale up of MDR TB enrollment. The low proportion of MDR TB patients who were enrolled to treatment can be caused by different barriers: 1. The PMDT service is not available or too far 2. The service our is not convenient for the patients who work 3. The distribution of enablers is problemmatic that it does not reach the patients 4. Afraid to access care because	To ensure that the proposed system work, arrangements should be made with different actors: 1. NTP to coordinate with the Dirjen Yankes and Dinas Kesehatan to set up decentralized PMDT services, one hospital in each district and follow up services in Puskesmas 2. The puskesmas will organize the community supporters with technical capacity to support confirmed cases until treatment enrollment 3. The MoH PR to implement a system of payment of the rewards for health workers 4. The community PR to implement reward payment system for the community supporter	NTP Community PR Dirjen Yankes Legal association SR under the community PR

of other barriers	5. The two PRs to develop and agree on the enablers payment mechanism in 2020 6. Under the community PR, a legal association SR will implement comprehensive legal support from IEC to legal aid	
Insufficient linkage of CSO to health facilities	Dinas kesehatan will be responsible to coordinate overall community approach, and Puskesmas will coordinate daily cadres' activities. With this arrangement, the Dinas Kesehatan that is equiped with a TB technical staff and a WASOR can focus in organizing district wise NGOs and CSO on specific tasks to deliver. • Dinas kesehatan to map the community support in each district to avoid overlapped implementation. The Puskesmas will organize the field implementation of community cadres. • In central level, the government and community PR will organize three monthly meeting di discuss challenges and find the solution for any problem that can not be solved in SR and SSR level • The PRs, SRs, and SSRs conduct regular meeting for data validation and solving common problems	Dinas Kesehatan Government PR Community PR
Insufficient numbers of competent human resources to implement TB program	1. MoH to conduct human resource needs assessment based on disease burden and programmatic gaps to improve numbers, quality, and placement of staff for TB program (management, laboratory, treatment, surveillance). 2. MoH to develop training plan up to district level 3. MoH to coordinate with MoF and MoHA to obtain the requested HR based on the assessment 4. MoH to increase the number of training conducted through distance learning platform	MoH, MoF, MoHA
Monitoring and evaluation		
Inadequate capacity to supervise and evaluate results of supervision from province to district level and district to health center level, including the community level.	MoH and community PR to develop program supervision guidelines. MoH and community PR to commit to reciprocally provide feedback of supervision and follow up on the results. Both PR to set up performance based evaluation in the project implementation manuals Both PR organize quarterly evaluation meeting in national level among PRs and national SRs, in provincial level among SRs, and in district level among SSRs	MoH and community PR, SR
Under performance of SRs and SSRs	Based on the performance of the current funding implementation, the low performing SR will receive	MoH and community PR

	funding on performance based. The PRs should put the restriction requirement in the project implementation manual Both PR optimize the internal control mechanism to the SRs and SSR One staff in each PR is responsible to follow the performance of SRs and SSR under their responsibilities The PRs to implement of risk-based supervision regularly from PR to SRs and SR to SSRs. The PRs to revise and disseminate PIM (project implementation manual) to the SR, partners, SSR,to improve knowledge and commitment in implementing TB program. PR to link budget allocation and transfer of funds with the SR and SSR performance. Possible termination" should be the final option	
The completeness and timeliness of routine reporting through SITB is not optimal due to difficulties in internet service, leading to the low motivation of health facility workers.	1. NTP to continue evaluation and development of the SITB platform to adapt to new technology and the needs of frontline users for real-time data. This includes increasing server capacity. 2. NTP to conduct randomized data quality assessment to health facilities and DHO, similar data quality assessment checklist used during TB Epi-review	NTP
Fail to link with the national ID number and civil registration	The MoHA engagement in the TB elimination movement will be an effective strategy. The presidential statement will have impact in engaging all ministries in this TB elimination movement. • MoH to coordinate regularly with MoHA to find the best operational solution between MoHA and MoH will be organize. • MoH to coordinate with BPJS to link with BPJS number. With the high coverage of BPJS, BPJS number can also an alternative to link with other health data source	MoH and MoHA
Fail to link SITB with different operational system or software of non NTP providers	• NTP to develop additional but simple reporting form or apps • The district health office can set up district wise arrangement on reporting mechanism. For example, simple apps to report a patient start TB treatment, then NTP form can be filled after validation.	NTP DHO
Procurement		
The long duration of the logistic procurement process at PPM, which may impact program implementation.	GF to evaluate procurement procedure at PPM to improve efficiency of logistic management. MoH to prepare alternative for other procurement	GF, MoH

	procedures	
Delays in customs clearance	- NTP to use a closer supervision to agencies providing procurement services. - NTP to enhance coordination with Dirjen Farmalkes (Directorate General of Pharmacy and Health Equipment), Directorate General of Custom, and Directorate General of Foreign Trade of Ministry of Finance. - NTP to prepare documents for customs clearance to timely handle imported materials; to quarterly monitor the 'last mile' distribution and stock at districts and facilities to ensure availability at facility level;	MoH, MoF, Customs authority
Local procurement poses higher price	- 25% of price related with taxation, both for raw materials and products. With the issue of TB elimination Presidential Decree, MoH will engage MoF to agree on tax reduction. MoH to conduct price renegotiation with vendors and e-catalogue price control - MoH to coordinate with the Minister of State owned Enterprise to push in country production of drugs and tuberculin skin test, and to obtain the best price for the life saving commodities and essential diagnostics that the public needs	MoH, Minister of State Enterprise (BUMN), ULP, LKPP MoF
In country supply chain	-	
Taxes for in-country distribution of commodities	The Ministry of Finance has issued tax exemption letter for the halth products procured with GF funding. MoH to approach the Ministry of Finance to discuss any irregularities of tax exemption during procurement. GF to approve that procurement and in-country distribution of commodities from GF budget via UN agencies	MoH - MoF GF –MoH – UN agency
Logistics management information system (LMIS) does not effectively capture essential logistics data or does not effectively transmit data to appropriate supply chain management personnel, or no system is in place	PR to work on improving reporting through on-going training and communication with provinces as well as conducting quarterly data review meetings when needed.	MOH
Grant related fraud and fiduciary		
Inadequate knowledge of applicable MoF regulation	Involve the internal audit unit of MoH during the planning meeting.	PRs and SRs
Accounting and financial reporting		
Incomplete, incorrect, delayed or inadequately supported financial records by PRs or SRs due to inadequate financial management systems	PRs and SRs to conduct cascade risk based supervision, monitoring, and evaluation of compliance to financial SOPs. Related to the monitoring evaluation part above, the financial reporting compliance is part of the evaluated subjects that has impact on SRs and SSRs performance	PRs and SRs

National program governance and grants oversight		
Insufficient or conflicting regulations	• MoH and MoHA will map the regulations that link to TB control, either supporting or inhibiting through the high level coordination in the central level. • MoHA to monitor regional regulations or plan of regulations that is negatively influence the TB control effort. With the authority of MoHA, coordinated effort to update or modify those regulations will be organize.	MoH MoHA Community PR
National or central level policy does not reach the implementer level in the expected speed	MoH and MoHA to use the communication platform in the government to ensure dissemination of new or updated policies	MoH MoHA
Quality of health product		
Quality of SLDs that purchased through Global Fund sometimes of poor conditions when it is arrived in national warehouse.	GDF to conduct quality control measurement before shipment of the commodities. PR logistic team to perform quality control measurement starting from port arrival, during custom clearance and before entering central warehouse.	GF, GDF PRs
Risk related to human right and gender		
Low legal, gender, equity and rights literacy	All PR to include human right and gender sensitization in their IEC materials and training The community PR to organize comprehensive legal support for TB patients and communities, and legal assistance for discriminated patients.	MOH, PRs
limited access to health services for vulnerable populations in a remote area	Increase collaboration with local NGOs, non-health sectors, and key persons/ cadres from the local community and communicate to them about the existance of the services.	PR non-government, MoH
Instability of the country		
Potential security disturbances in several districts in highland Papua have an impact on program implementation (TB-HIV)	Activities conducted at the local level if security guarantees from local government are obtained. Arrange an emergency stock of medicine to anticipate security disturbance in Puskesmas, community health workers, and additional stock for the patients	DOH, POH, MoH
Other emerging risk		
Potential disturbances of program management and service delivery due to emerging pandemic situation	PRs to develop business continuation plan and preparadness PRs to allocate resources for mapping, situation assessment, analysis and mitigation action to reduce negative impact of pandemict. PRs to conduct post pandemic assessment to measure impact and informed decisions to overcome	PRs MOH, Development partners (WHO, UNDP)

Note: No major risks are foreseen in macroeconomic factors, and political risks

Section 4: Co-Financing, Sustainability and Transition

To respond to the questions below, refer to the *Instructions*, the domestic financing section of the **allocation letter**, **the** Sustainability, Transition and Co-Financing Guidance Note**,Funding Landscape Table(s), Programmatic Gap Tables(s)**, **and a sustainability plan and/or transition work-plan**, if available[4].

4.1 Co-Financing

a) Have **co-financing commitments** for the **current** allocation period been realized?

☒ Yes ☐ No

If **yes**, attach supporting documentation demonstrating the extent to which co-financing commitments have been met.

If **no**, explain why and outline the impact of this situation on the program:

Tabel 4.1.a. The contribution of domestic funding source for the TB program in 2018-2020

Year (USD)				
	2018	**2019**	**2020**	**Total**
Total Domestic Funding	$97.638.016,17	$89.055.551,52	$112.203.219,23	$298.896.786,92
Central Government (APBN)	$42.461.395,45	$40.462.572,59	$59.161.010,81	$142.084.978,84
Special Allocation Funds(DAK Penugasan dan reguler)	$-	$-	$24.653.818,04	$24.653.818,04
MOH (operasional dan penelitian)	$377.883,79	$660.385,54	$632.355,76	$1.670.625,08
Deconcentration (PHO)	$496.788,31	$771.125,33	$598.694,85	$1.866.608,50
Deconcentration (KKP)	$201.298,79	$275.672,01	$242.111,95	$719.082,75
Deconcentration (BTKL)	$54.775,18	$81.951,62	$63.527,92	$200.254,72
Anti TB Drugs (APBN)	$21.756.542,88	$22.659.631,54	$24.925.594,69	$69.341.769,11
Lab Consumables (APBN)	$19.574.106,49	$16.013.806,55	$8.044.907,60	$43.632.820,63
Health Insurance (BPJS)	$36.485.405,03	$29.225.966,59	$33.257.008,64	$98.968.380,26
Provincial Government (APBD I)	$243.840,28	$634.741,78	$580.881,19	$1.459.463,26
District Government (APBD II)	$18.447.375,42	$18.732.270,56	$19.204.318,58	$56.383.964,56

The above program financing information is limited to the central and sub-national government budget and health insurance. It has not yet included non-health sector ministries, government agencies that are also working on tuberculosis-related activities/programs and contribution from the private sectors. The sub national government contribution may be underestimated due to under reporting. The Health Insurance budget for 2020 is an estimation based on average of 3 years historical actual expenditures of BPJS for TB (2017-2019). The ongoing revision of reimbursement tariff and also the case-based grouping system may affect the size of JKN medical spending for TB in the near future.

b) Do **co-financing commitments** for the **next** allocation period meet minimum requirements to fully access the co-financing incentive?

[4]Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund.

☒ Yes ☐ No

If details on commitments are available, attach supporting documentation demonstrating the extent to which co-financing commitments have been made.

If co-financing commitments do not meet minimum requirements, explain why.

Based on the allocation letter, to access the co-financing incentive, PR Tuberculosis should at least meet the requirement of 20% co-financing from total allocation amounting USD 150,456,123 or equal with USD 30,091,225. According to the National TB Strategic Plan 2020-2024, NTP expected to have USD 292,328,653 from domestic central government funds (APBN) for TB control program during 2021-2023 period.

Tabel 4.1.b. The expected contribution of domestic funding source for the TB program in 2021-2023

Year (USD)				
	2021	2022	2023	Total
Total Domestic Funding	$145.301.085,18	$161.754.273,35	$178.390.900,04	$485.446.258,57
Central Government (APBN)	$86.925.611,86	$97.574.653,37	$107.828.388,76	$292.328.653,99
Special Allocation Funds (DAK Penugasan)	$37.717.691,83	$45.261.230,20	$54.313.476,24	$137.292.398,27
MoH (Operational)	$768.269,31	$845.096,24	$929.605,86	$2.542.971,40
Deconcentration (PHO)	$894.958,64	$939.706,57	$986.691,90	$2.821.357,10
Deconcentration (KKP)	$157.545,70	$165.422,99	$173.694,14	$496.662,83
Deconcentration (BTKL)	$23.483,24	$24.657,40	$25.890,27	$74.030,90
Anti TB Drugs	$39.788.668,95	$42.006.046,37	$42.233.287,39	$124.028.002,71
Lab Consumables	$7.574.994,19	$8.332.493,61	$9.165.742,98	$25.073.230,78
Health Insurance (BPJS)	$36.582.709,51	$40.240.980,46	$44.265.078,50	$121.088.768,47
Provincial Government (APBD I)	$668.013,37	$701.414,04	$736.484,74	$2.105.912,15
District Government (APBD II)	$21.124.750,44	$23.237.225,49	$25.560.948,03	$69.922.923,96

The above program financing information is limited to the central and sub-national government budget and health insurance, it has not included non-health sector ministries, government agencies that are also working on tuberculosis-related activities/programs and contribution from the private sectors.

c) Summarize the **programmatic areas** to be supported by domestic co-financing in the next allocation period. In particular:
   i. The financing of key program costs of national disease plans and/or health systems;
   ii. The planned uptake of interventions currently funded by the Global Fund.

1. The financing of key program costs of national disease plans and/or health systems:
   - One major expenditure for TB program activities especially for **TB care and treatment** is coming from **the National Health Insurance (BPJS) program**. The payment for TB treatment services covered (excluding anti TB drugs) both outpatient and inpatient service at primary care and hospital is estimated to be above USD 30 million per annum. National Health Insurance (BPJS) provide treatment service and clinical management costs of drug sensitive TB. For the drug resistant TB, the service payment will be taken over stepwisely by BPJS. Part of the drugs, tests, and consummables of DR-TB is paid by the National TB Program budget. This will be shifted to BPJS starting from 2022. Currently it is difficult to measure financial contribution for DR-TB treatment since the absence of specific coding for DR-TB, meanwhile NTP has acknowledged that treatment support for some DR-TB patients already covered by BPJS. By joint introduction of single account for all health funds (One regulation, one benefit package, one accountability mechanism) from MoH and BPJS in 2021, NTP will have better change to measure the resource allocation.
   - Domestic financing has been mainly used for case management, program management, and

human resource development, and also health system strengthening; The Central Government (APBN) with USD 101,3 million per year, financing covers the **program management specifically for monitoring and evaluation activities, assessment of the epidemic status, training of trainers (ToT) (23million USD, national and sub-national, 2018), and procurement of commodities such drugs and laboratories consumables (25,5million USD central government**; 2018 and increase to 37,4million in 2020);

- The national resource (APBN) allocated the procurement of **100% first line intermitten dose TB drugs regimen and 20% of second line TB drugs, laboratory supplies and consumables (buffer stock), and** to pay the salary of **TB program focal staffs.**The procurement of anti TB drugs (OAT) has been under the management of the DG Pharmaceutical Services to cover annual needs and also the required buffer stock. **The provincial and district resource (APBD) pay for laboratory supplies and consumables** ;
- Deconcentration Funds (Dana Dekonsentrasi) is a sectoral intergovernmental transfer fund mechanism to the central representatives such as the Province Health Office, BBTKL (public health laboratory), and Port Health Authority (KKP). The fund has various menu options that are intended to ensure central functions to address across district/regional issues. The provincial deconsentration fund is is to finance activities to strengthen surveillance system, technical supports TB program management. Meanwhile, the BBTKL and KKP deconsentration fund is mainly for TB case finding and coordination meeting with related stakeholders, i.e. Imigration Office, Border authority;
- The contribution from the **local Governments, and budget allocated from other sectors, as well as Village Funds** are not yet traceable for the use of Tuberculosis prevention and control activities. Future allocation of Village Funds is related with **nutritional supports, contact investigation, defaulter tracings and local focus group discussion, referral supports**, etc.;

2. The planned uptake of interventions currently funded by the Global Fund:

The domestic funding take over more and more the GeneXpert cartridges procurement. The proportion of second line drugs procured from the national budget will increase and will be taken over almost entirely on 2023.

Different local resource actually exists but not optimally used and not easy to trace. We propose the GF support for conducting advocacy activities that will revive or stimulate these sources.

- The GF financing covers areas of activities that did not receive funding support from the government budget, especially related with community advocacy, improving TB awareness, community strengthening and service delivery. These intervention will be overtaken by district budget, other ministries funds, supported with clear government regulation related with TB, including with influence of a Presidential regulation for TB control.
- Increase government allocation for public goods (drugs, consumables) and public health functions (contact investigation, tracing, supervision) and human resource development of health workers, including community.
- Improve efficiency of national health insurance through effective referral system from secondary/ tertiary care to primary care providers.
- Innovative approaches with information technology to reduce TB program operational costs, i.e. trainings, coordination mechanism.

d) Specify how co-financing commitments will be tracked and reported. If public financial management systems and/or expenditure tracking mechanisms require strengthening and/or institutionalization, indicate how this funding request will address these needs.

- Different regulations direct the Indonesia's public financial information system depending on the administrative level; the central level follows APBN regulation, while sub national levels follows the MoHA Regulation. On the other hand, most districts have implemented e-budgeting system that is designed to allow direct reporting to the central government. The classification, codification, and nomenclature of the local government plan documents, budget documents, and financial statements only show information up to the sub-activity level. It is still not possible to getdetailed activities for each sub. The new government budget nomenclature has made it more challenging to obtain

detailed information. Another challenge is that AIDS, TB, Malaria (ATM) related activities are often budgeted under or as parts of other sector activities by implementation time.

- Comprehensive and integrated planning and budgeting with different streams of financing to district level government budget and JKN payment as the largest two sources of health financing is planned. The recent development such as the changes of public financial management regulations and the implementation of the JKN program affect the ability to track program related spending. This issue has been recognized as the root cause of the unavailability of health financing information.
- NTP with other disease program will advocate for improved collaboration across various units within MoH for the improvement in the public financing nomenclature system. These concerted efforts are needed to establish the interoperability of the SITB, ASDK, and more importantly the BPJS Health P-Care System (Primary Care information system) and the V-Claim (hospital level information system). The NTP M&E team would provide proposed program indicators (definition, data source, reliability and validity check, etc).
- NTP will coordinate with the Center of Health Financing and Health Insurance (P2JK) to obtain BPJS data related with tuberculosis services provision, including membership and service utilization information from both primary and referral facilities. NTP will liaise with academics and development partners to explore other options including identify available data sources that could yield program financing information, and the possibility to conduct small(er) scale analysis to track tuberculosis program expenditure.

4.2 Sustainability and Transition

a) Based on the analysis in the **Funding Landscape Table(s)**, describe the funding need and anticipated funding, highlighting gaps for major program areas in the next allocation period.

Also, describe how(i) national authorities will work to secure additional funding or new sources of funding, and/or(ii) pursue efficiencies to ensure sufficient support for key interventions, particularly those currently funded by the Global Fund.

According to TB NSP 2020-2024 total funding need for TB Program is USD 2,055,547,763.73 for 2021-2023 and 82% of it needs is from strategy #2 ***"Improve access to patient centered and good quality TB service"***.
The co-financing commitment from GOI aprox USD 424,132,284.41 for 2021-2023. The total gap of funding is approximately 79%.

To cover the total gap of 79%, the program will conduct strategy as follow :

1. Advocacy to House of Representative for additional fundings commitment earmarked for TB (i.e. diagnostic tools, drugs and prevention tools)
2. Reducing the total funding need with effort to optimize efficiency by identifying cross cutting activities such as domestic procurement for health product from local manufactures.
3. Remove regulation barrier related health product procurement with Presidential decree for TB Control.
4. Decentralization of services to primary care level rather than expensive secondary care.
5. Increase contribution of funding from the national health insurance, especially for DR TB services
6. Increase utilization of funding from other ministries, take advantage of presidential decree for TB Control
7. Increase funding allocation from district government to fulfill funding need under minimum services standar (SPM)
8. Mobilize funding from CSR, philantropy and social funds to provide support and enabler to TB patient
9. Integrated phsycosocial supports for TB patient in the social protection scheme of GOI.
10. Mobilize external donor other than GF to fund the uncovered activities

b) Highlight challenges related to sustainability (see indicative list in *Instructions*). Explain how these challenges will be addressed either through this funding request or other means.If already described in

the national strategy, sustainability and/or transition plan, and/or other documentation submitted with the funding request, refer to relevant sections of those documents.

1. The capacity for clinical care payments in Indonesia has vastly expanded via the national health insurance scheme (JKN). With the possibility of declining external fundings, the sustainability of the NTP becomes an issue. The expansion of JKN established the foundation for sustainable funding of quality TB clinical care in the public and private sectors. The recent decision by BPJS to test innovative payment mechanisms that encourage TB case management at the primary care level creates the potential to substantially improve program performance at lower cost.The integration of service delivery from externally financed and vertically managed programs, such as current national TB control program, into JKN in a decentralized setting has become one of the key policy discussions to ensure the programmes' future. Those concern needs to be discussed within the overall health system context and take into account all the health system pillars, and will include:
    - preparedness to provide the covered services;
    - better responsiveness and sensitivity to the needs of specific target population groups;
    - provider-payment mechanisms that incentivize providers to reach out to target beneficiaries and retain them in the treatment cascade.
2. Domestic resource mobilization to ensure the sustainable tuberculosis program financing by generating and maintaining the commitments of central and local government has been initiated through political commitment strengthening. The Presidential Initiative and Decree are expected to encourage provincial and district-level authorities to prioritize TB control in local budgets and to hold local health authorities accountable for TB care and prevention performance. It can also draw in greater multisectoral engagement to address the social determinants of TB, lead to better care for TB within specific vulnerable populations, and hold responsible authorities to account. There are existing programs from the Government of Indonesia such as village funds, BOK and several social protection scheme that have the potential to support the efforts to ensure program sustainability at the time when GF and/or other donor funds have decreased.

3. The focus of the Ministry of Finance to increase the efficiency of public expenditure encourage better planning and the quality improvement of tuberculosis program expenditure.. In the above section, NTP will ensure coordination of planning and budgeting across different government levels to avoid duplication of activities. Various quality measures, strengthening supervision and monitoring, establishing interoperability across various information systems (ASDK), including with the BPJS Health information system in the long run, will improve efficiency and improve the value of the investment regardless of the sources of funds.
4. Implement measures to ensure the quality of service as well as continuity of service, patient centered care, are applied under the JKN payment scheme. These measures may include, but not limited to, linking provider payment with their performance in TB notification and treatment success, try out different payment mechanism for diagnostic test (unbundling payment - pay per service) to ensure continuity of care.
5. Innovative approach for HCW capacity building. Improving the capacity of health personnel through training has been relying on GF financing. The use of traditional face to face in-service training is limited by time (limited man-days) and distance (geographical barriers). The development of innovative training methods using technology such as long-distance learning has been formally adopted by MOH.
6. PSM strengthening to improve efficiency of procurement process and avoid excess spending for commodities by strengthen the forecasting and procurement mechanism, clarifying the division of roles and responsibility between the Central and the sub national level. Also important for NTP and the Directorate of Program Pharmaceuticals Provision, DG of Pharmaceutical services, and the national procurement agency (LKPP) to to ensure the availability of tuberculosis treatment and supplies with most reasonable prices .

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

V☐	Funding Request Form
V☐	Programmatic Gap Table(s)
V☐	Funding Landscape Table(s)
V☐	Performance Framework
V☐	Budget
V☐	Prioritized above allocation request (PAAR)
V☐	Implementation Arrangement Map(s)[5]
V☐	Essential Data Table(s) (updated)
V☐	CCM Endorsement of Funding Request
☐	CCM Statement of Compliance
V☐	Supporting documentation to confirm meeting co-financing requirements for current allocation period
☐	Supporting documentation for co-financing commitments for next allocation period
☐	Transition Readiness Assessment (if available)
V☐	National Strategic Plans (Health Sector and Disease specific)
☐	All supporting documentation referenced in the funding request
☐	Health Product Management Tool (if applicable)
V☐	List of Abbreviations and Annexes

[5]An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage.