Indonesia National Tuberculosis Program: Planning for Financial Sustainability

David Collins, Director, Finance & Accounting (MSH)
Attin Parihatin, Technical Officer for ACSM (KNCV)

December 2011

USAID FROM THE AMERICAN PEOPLE | TB CARE I

msh Management Sciences for Health

KNCV TUBERCULOSISFOUNDATION

This report was made possible through the support for the TB CARE I provided by the U.S. Agency for International Development (USAID), under the terms of cooperative agreement number AID-OAA-A-10-00020.

Abstract

This report describes recommended actions for the National Tuberculosis Control Program (NTP) to consider in developing its Exit Strategy implementation plan. It also describes a set of recommended technical assistance and training activities aimed at supporting the NTP in this process. These recommended actions and activities were based on document reviews and on discussions with NTP members, USAID and other partners. The recommended actions can be summarized as: increasing the domestic share of funding through improved advocacy and planning and budgeting; expanding income from social insurance and corporate social responsibility schemes; and ensuring that existing and additional services, including new diagnoses and treatments, are provided in the most cost-effective and efficient ways possible.

Recommended Citation

This report may be reproduced if credit is given to TB CARE I. Please use the following citation: Collins, D and A. Parihatin. 2011. *Indonesia National Tuberculosis Program: Planning for Financial Sustainability*. Submitted to USAID by the TB CARE I Program: Management Sciences for Health.

Key Words

TB, Indonesia, Sustainability, Advocacy, Planning, Budgeting

Disclaimer

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Management Sciences for Health
784 Memorial Drive
Cambridge, MA 02139
Tel: +1(617) 250.9500
Fax: +1(617) 250.9090
www.msh.org

CONTENTS

ACRONYMS

ACSM	Advocacy, Communication, and Social Mobilization
AIDS	Acquired Immune Deficiency Syndrome
APBD I	Provincial Development Budget
APBD II	District Development Budget
APBN	National Development Budget
ATM	HIV/AIDS, Tuberculosis, and Malaria
AusAID	Australian Agency for International Development
DOTS	Directly Observed Therapy, Short-course *(the Internationally Recommended Standard for Tuberculosis Control)*
GF	Global Fund
HIV	Human Immunodeficiency Virus
HR	Human Resources
KNCV	*Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculosis*
PMDT	Programmatic Management of Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant Tuberculosis
MOH	Ministry of Health
MSH	Management Sciences for Health
MT-NDP	Medium Term National Development Plan
NTP	National Tuberculosis Control Program
SOW	Scope of Work
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TB CARE I	Tuberculosis CARE I Program
TBCTA	Tuberculosis Coalition for Technical Assistance
TORG	Tuberculosis Operations Research Group (NTP)
USAID	United States Agency for International Development
WHO	World Health Organization
XDR-TB	Extremely Drug-Resistant Tuberculosis

ACKNOWLEDGMENTS

The authors wish to thank the Director and staff of the NTP and the members of the USAID team who support the TB control program.

David Collins is the Director of Finance for Management Sciences for Health and Attin Parihatin is the Technical Officer for ACSM for KNCV.

1.0 BACKGROUND

The objectives of this assignment were to (1) design a study on cost/benefit analysis of Tuberculosis (TB) control in Indonesia and related advocacy materials, and (2) prepare a plan for rolling out the Planning and Budgeting Tool[1]. During the course of the assignment, however, it became clear from discussions with the National Tuberculosis Program (NTP) that a broader scope of work was needed. The scope was revised to assisting the NTP to develop a plan for their Exit Strategy and to recommend a set of actions for successful implementation. This included the design of the cost/benefit analysis and planning for the planning and budgeting work, but also had other elements.

The following steps were followed to collect information and discuss findings:

1. A literature search was conducted and relevant documents were retrieved for reference.
2. The World Health Organization (WHO) was contacted to get information on the use of the Planning and Budgeting Tool at the sub-national level.
3. A briefing meeting was held with the NTP districts and senior staff in which background information was provided and the needs of the NTP were expressed.
4. Meetings were held with the United States Agency for International Development (USAID) to discuss the scope of work and to get information on the Global Fund.
5. Two workshops were held with NTP focal points (Monitoring and Evaluation [M&E], Advocacy, Communication, and Social Mobilization [ACSM], Human Resources [HR], TB Operations Research group [TORG]) to collect information and discuss the overall design of the work.
6. Briefings and advice were provided by the Ministry of Health (MOH) planning bureau chief and University of Indonesia experts.
7. Discussions were held with other USAID-funded projects
8. The proposed overall design was presented to the NTP and was approved. The NTP provided additional information and requests which were incorporated. The modified proposal was then presented to USAID.
9. The proposed overall design was also presented to the TORG.
10. Follow-up discussions were held with the NTP and USAID during the Lille conference.

[1] The original detailed Scope of Work (SOW) is in Annex 1.

2.0 HEALTH AND TB SITUATION ANALYSIS AND PLANS

2.1 Health situation and plans

The health of its 240 million citizens is one of the major challenges facing Indonesia. Infant and child mortality rates are high, it has the fastest growing HIV/AIDS prevalence rate in Southeast Asia, and malaria kills an estimated 30,000 Indonesians every year.

Health development is a priority for the Government, and its general strategies, which are stated in the Medium Term Development Plan 2010-2014[2], are to:

1. Improve involvement of the community, private and civil society in health development through national and global partnership;
2. Increase equality, equity and quality of evidence based health care;
3. Increase health financing, particularly to provide a national social health insurance scheme;
4. Improve quality and distribution of human resource development and utilization;
5. Increase availability, distribution and affordability of drugs and medical devices, while maintaining safety, efficacy, effectiveness and quality of pharmacies products, medical equipments and food; and
6. Improve accountability, transparency, efficiency and effectiveness of health management, particularly at the decentralized levels.

The MOH has highlighted the need for healthcare reform to respond to public health problems. The objectives of healthcare reforms are to: (1) provide a health financing scheme which cover basic medical care for all population; (2) provide health financing for basic promotive and preventive healthcare; (3) provide drugs/medical equipments for maternal and child health, malaria, TB and HIV/AIDS control; (4) establish the strategic function, performance and good governance in the MOH; (5) provide health resources in remote and borderline areas and islands; (6) provide health resources for areas classified into low/poor category of specific health problems; (7) provide resources, law and regulation in healthcare to support the development of international accreditation for hospitals.

2.2 TB situation and Government plan

The rapid expansion phase of TB control program in Indonesia (2006-2010) reached wider communities, including the poor and vulnerable population, expanding the types of health facilities implementing DOTS strategy (hospitals, clinics, etc.), implementing Directly Observed Therapy, Short-course (DOTS)-plus strategy, and integrated TB-HIV services. As a result, Indonesia has improved its outcomes, having reached an estimated annual prevalence of all TB

[2] Breakthrough Toward Universal Access. The National TB Control Strategy: 2010-2014. Pre-Final Draft, Ministry of Health, Republic of Indonesia.

cases mounting to 244 per 100,000 population and an estimated incidence of new cases reaching 228 per 100,000 population (WHO, 2009).

However, major challenges remain. One of these relates to Multi-Drug Resistant TB (MDR-TB), where a high defaulter rate and the irrational use of second-line drugs in hospitals and the private sector are contributing to the increase of cases which is expected to reach over 5,000 by 2014. Another challenge is that of access. Out of the existing 482 districts in Indonesia, 138 are officially recognized by the government as underserved districts, mostly in remote areas. Other access challenges exist among the urban poor.

Health services are decentralized to the district level. Each district has one or more hospitals and is supported by primary health care facilities (microscopic centers, satellite health centers, and independent health centers). Currently, Indonesia has 1,649 microscopic health centers, 4,140 satellite health centers, and 1,632 independent health centers. The majority of the government facilities are established DOTS facilities but most of the private facilities are not (Table 1)[3].

Table 1. Number of DOTS facilities in 2007

Health facilities	**Total**	**% of DOTS health facility**
Health center	7,352	7200 (98%)
Chest clinics	29	29 (100%)
Private practitioners	55,000	Data not available
Hospital:		370 (29%)
- Lung hospital	8	8 (100%)
- Public hospital	426	213 (50%)
- Parastatal hospital	52	6 (12%)
- Military hospital	93	31 (33%)
- Police hospital	32	7 (25%)
- Private hospital	615	101 (15%)

The Government's TB control strategy has the goal of sharply decreasing the disease burden of TB by the end of 2014 through ensuring universal access to quality diagnosis and patient centered quality treatment, including the prevention and cure of MDR-TB cases[4]. The plan is in line with the Strategic Plan of the Ministry of Health and is fully embedded in the Medium Term National Development Plan (MT-NDP) for 2010-2014. In February 2010 the President of the Republic of Indonesia issued an instruction indicating TB control as one of the main priorities of the MT-NDP in national efforts to achieve the Millennium Development Goals (MDGs). These actions demonstrate strong national ownership for TB control.

The objectives of national strategy for TB control in Indonesia, 2010-2014 are the following:

1. Quality DOTS service are scale up and improved.

[3] The number of health centres quoted in the text may be for a different year that 2007.
[4] Ibid.

2. TB-HIV, MDR-TB, and the needs of poor and other vulnerable groups are tackled.
3. All public, community and private health providers are implementing International Standards for TB Care.
4. Community and TB patient empowerment
5. Strengthen the health system and TB control program management
6. Strengthen the central and local government commitment for TB control program[5]
7. Improved research, development and utilization of strategic information

2.3 TB financing

The Government's allocation of financial resources for health has gradually increased every year. In 2009, total government budget for the operation of the TB control program was 145 billion Rupiah, an increase of 7.1% compared to the previous financial year, which was 135 billion Rupiah[6]. Despite this increase, the government only contributed 23.4% of the total national budget (621.5 billion rupiah) required for TB control. International donor funding, e.g. Global Fund, USAID, and others, was used to meet the financial gap, which reached up to 269.36 billion Rupiah in 2009, a 45% increased compare to previous year. Budget escalation for TB control program in Indonesia was triggered by motivation to accelerate progress toward the MDGs. However, funding obtained from the central and local government, supported with international funding remains insufficient to cover all costs needed for the TB control program. As of 2010, there was still a projected 31% deficiency in the total budget for TB control, although that was lower than the budget deficiency in 2009, which was at 39%.

A focused financial strategy is needed to close the financial gap by increasing budget contributions from the local and central governments. Up to date, local (province and district/municipality) government commitment to fund TB control program is still low, approximately 45% to 49% of total budget from the central government. In many districts there is fiscal space for TB control program budget improvement from local government but even in these cases local funding generally needs to improve significantly and continuously. In some cases the district governments only allocate between 1% and 4% of the total local development budget (APBD) to health (Government policy stipulates at least 10%). Such underfunding is especially important since this funding is used for routine TB program activities like monitoring and supervision.

Endorsement of resource allocation policy becomes another important factor to promote continuous allocation of health budget for TB control program. Through accurate budget allocation and a local economic growth of 6-7% (National Statistic Bureau) it is expected that the current gap in the health budget for TB control program would decrease from 31% in 2010 to 13-15% in 2014, by strengthening local capacity and local commitment to achieve target indicators of MDGs in 2015.

Finance objectives are included under Objective 6 in the TB Control Strategy and are described in Strategy 5.6. In summary, they are: increasing the **funding allocation** for TB control program from central and local government and support and **increasing resources** from other

[5] Financing activities are included here.
[6] The National TB Control Strategy: 2010-2014

stakeholders. The plan contains two finance indicators: (1) Proportion of national government funding (APBN) for procured drug including buffer stock, and (2) Proportion of local funding (APBD) for TB control.

Several important steps have already been taken to improve financing, including the following:

1. Mandates by the central government that 5% of national allocations and 10% of provincial and district allocations must be for health, and 20% of each district health budget must be spend on AIDS/HIV, TB and Malaria (ATM) (Health Law (UU No 36 Tahun 2009).
2. The establishment of a system for each district to report the allocations to TB annually to the central level.
3. Movements to improve insurance coverage for TB, including an agreement reached with Jamsostek (Jaminan Sosial Tenaga Kerja) (Workforce Insurance) in 2010.
4. An analysis of the cost and benefit of TB control that was carried out in 2005 and has been used by the NTP for advocacy.[7] An analysis of TB program in 7 districts was conducted in 2008.[8]
5. A pilot activity undertaken in 2010 to improve the planning and budgeting of TB activities at district levels. [9]

Despite the central government mandate, the latest national health budget figure shows only an allocation of 1.9% to health, which represents a decline from 2.2% in the previous year.[10] Although this represents an increase in Rupiah terms, the decline in relative terms indicates that challenges remain. This amount is much less than the 5% minimum required under the central mandate.

A separate finance issue relates to access issues. According to the National Strategy, one of the reasons why TB program targets have not been achieved relates to hospital fees charged to TB patients. A similar issue relates, reportedly, to the patients sometimes having to pay for laboratory tests. In both cases, the expansion of insurance coverage will help to improve access.

[7] TB Program and Poverty Alleviation. Ascobat Gani, FKMUI. August 26, 2005.

[8] Health Financing Analysis of the TB Program in 7 Districts of 4 Provinces in Indonesia. 2008. Center of Health Research, University of Indonesia.

[9] A pilot activity was carried out with 10 districts / municipalities in Central Java. The NTP selected Central Java province because the provincial office was interested and the province is easily accessible. The NTP selected the 10 districts to include 4 that had already had some training in the tool and the other 6 had none. The province and districts also have greater fiscal capacity (more funds). Some earlier work was done in 14 districts in 7 provinces but we have not yet been able to find details.

[10] According to the MoH budget for 2010 - National Budget and Expenditures Plan (Anggaran Pendapatan Belanja Nasional [APBN]) Rp 20,8 trillion was approved which was more than 2% of the total APBN. In 2011, the MOH budget increased to Rp 26,2 trillion (almost 3%) but it was later changed in the APBN Perubahan to 1,94%.

2.4 Global Fund Proposal

The GF Round 10 proposal aims to cover the period from July 2011 through June 2016. It identifies the main challenges to be addressed to support the Govenment to achieve its objectives. These include the following challenges relate partly to finance:

- The recent slowing down of progress in TB case detection due to under-notification, barriers in access to diagnosis and diagnostic delays.
- Shortage of skilled human resources due to establishment of new districts and consequences of decentralization policy leading to high staff turn-over, staff shortages, and a considerable training backlog.
- High reliance to donor funding and lack of local ownership resulting in low local financial support to sustain the TB control program.

The goal of the GF Round 10 proposal is help achieve the MDGs for TB control by improving access to quality DOTS services by strengthening health systems and expanding community networks.

The following are the main objectives:

1. Objective 1: Increased access to quality DOTS services to al TB patients and Programmatic Management of Drug Resistant TB (PMDT) services for all MDR patients, with a focus on vulnerable groups and remote areas.
2. Objective 2: Strengthened health systems with focus on improving quality of service delivery and optimizing TB case management:
3. Objective 3: Strengthened community systems to empower communities to support and sustain TB control.

Under Objective 2, the following finance strategies are planned:

1. Improve financing to ensure optimal accountability of funding and embedding planning for TB control in national and local development budgets (APBN, APBD), gradually phasing out external donor support.
2. Conduct activities to ensure budget lines for TB control in local government budgets (APBD): refer to ACSM. This activity relates to SDA 1 under Objective 3.
3. Establish collaboration and coordination with national health/ social security schemes like AsKes (National Health Insurance) JamSosTek (Social Security for workers/labour), JamKesMas (Community Health Insurance system), Jamkesda (Local Government Health Insurance).
4. Develop regulations under the Ministry of Finance for incorporating TB in national and local insurance schemes and establish reimbursement systems for health workers providing care to TB patients. This intervention is essential to sustain operational activities for TB control after donor funding stops. Seed money is required to link the national program with national insurance schemes like JamkesMas, and AsKes and linking district TB programs will local insurance schemes under JamKesDa.

To achieve these objectives the NTP will work with the SR Planning bureau MOH, National Planning Board.

The importance of cost effectiveness and efficiency are also included in the Global Fund (GF) proposal under the topic of Value for Money in Section 4.5.3, which includes several interventions which are deemed to have low costs and high expected returns. These are the:

- Inclusion of TB in minimal service standards and in accreditation standards for hospitals and providers.
- Expanding and involving more community/women organizations and shifting certain TB control tasks (suspect identification, suspect referral, treatment monitoring) to communities, particularly in hard to reach areas and populations.
- Better pricing, waste prevention and program integration relating to medicines procurement and supply change management.
- Integration of interventions with existing interventions delivered by the national AIDS control program.

The Conditions Precedent for the GF Round 10 do not include any conditions related to finance except that the Principal Recipient undertakes to use reasonable efforts to find alternative sources of funding for the performance based incentives to the TB health workers (the "Performance Incentives").

3.0 SUMMARY OF FINANCING STRATEGIES

Although sustainability has been stated as a high priority by the MOH, the related activities are somewhat buried in the plans. It is recommended that the topic be given rather more prominence in future plans since sustainability is key for all the elements of the plans (especially diagnosis and treatment).

Through the situation analyses and plans described above we can identify the key financing challenges for the TB program as follows:

1. Scaling up to meet the need for expanding coverage, especially for MDR-TB, will result in significant increases in costs.
2. A major part of the TB control program is funded by donors.
3. Donor funding is likely to decrease over the next few years and a major part of it may cease completely after the new GF grant ends.

These relate primarily to the sustainability of the program after the GF Round 10 funding ends in 2016 but with the scaling up of the program and general cutting back in donor funds it is important to also look at short and medium-term affordability.

The NTP has developed an Exit Strategy aimed at greatly reducing the dependency on GF support[11]. This has set a target for increasing the Indonesian proportion of TB program funding to 80% by 2016.

The key strategies for addressing these issues are:

1. Increasing the domestic share of total TB control funding through improved advocacy and planning and budgeting.
2. Expanding income for TB from social insurance and corporate social responsibility schemes.
3. Ensuring that existing and additional services, including new diagnoses and treatments, are provided in the most cost-effective and efficient ways possible.

Although the topics of cost effectiveness and efficiency are not prominent in the plans[12] they are extremely important, since the scaling up of services, especially MDR and Extremely Drug-Resistant Tuberculosis (XDR-TB), will place a significant extra financial burden on the system and will make it harder to achieve greater sustainability. Ensuring cost-effectiveness and efficiency across all aspects of TB control will keep the costs as low as possible and will greatly enhance sustainability.

[11] Post Global Fund Financing Exit Strategy of TB Control in Indonesia. Power Point. NTP. Undated.
[12] They are only really covered under "Value for Money" in the Global Fund proposal.

4.0 EXIT STRATEGY ELEMENTS

The three main elements of the Exit Strategy are set out below. These should serve as the foundation for the Exit Strategy implementation plan.

Element 1: Increasing the domestic funding share

Much of the district funding for TB comes from the district government health budget and the allocation to TB is, therefore, constrained by the amount of funds allocated to health. This allocation to health services has remained less than optimal in some places and although the central government has mandated allocation levels it remains to be seen how widely these mandates have been followed. There are a number of reasons for this problem, including a lack of knowledge of the resources required to meet health needs (costs), weak health planning and budgeting capacity, a lack of good financial advocacy materials and capacity, a budgeting process that hampers prioritization according to needs because of ceilings, and possibly a perception that the health sector has significant donor funding.

In addition to the lack of health funds the proportion of those funds allocated to TB is inadequate. The main reasons for this are the attitude of district health managers that TB control is well-funded by donors, a lack of good advocacy materials and capacity re economic benefits of TB control and weak TB program planning and budgeting capacity.

National government has set policies to improve these allocations but support is needed to improve implementation.

This element has two main activities.

1. Increasing allocations to the district health office by:
    a. Improving advocacy and motivation for local government to increase funding for health.
    b. Improving district health office planning and budgeting.
2. Increasing district health office allocations to TB by:
    a. Improving economic advocacy and motivation for district health offices to increase funding for TB.
    b. Improving TB planning and budgeting.

Element 2: Generating additional funding from non-government sources

Insurance reimbursements for TB, and perhaps for other services, are not maximized because coverage is not universal and benefits are across the different insurance schemes that people belong to. In addition, donations from corporate social responsibility schemes could be greater if there were better advocacy materials and skills.

This element has two activities:

1. Maximize revenue earned from insurance.
2. Increase donations from corporate social responsibility schemes.

Element 3: Cost-effectiveness and efficiency

A TB control program has several areas where cost-effectiveness (doing the right thing) is critical. Examples may be prioritizing the continuity of treatment for freed prisoners and the use of DOTS for MDR-TB treatment. Efficiency is also important, such as in the procurement and distribution of drugs. Keeping costs as low as possible will make it much easier for the program to be sustainable.

This element has one activity:

1. Review the major cost elements of TB control in general and analyze their effectiveness, identify where savings can be made and develop interventions to achieve them.
2. Carry out an in-depth study of projected costs for all TB costs in one district using GeneXpert and providing MDR-TB treatments in general and in the prison system.[13]

The proposed activities are set out in detail in the following section.

[13] This activity was added following discussions with USAID and the NTP at the Lille conference.

5.0 PROPOSED TECHNICAL ASSISTANCE ACTIVITIES

These are intended to cover the length of the project

1. **Exit Strategy**

   - Develop an implementation plan for the NTP's Exit Strategy.

2. **Element 1: Increasing the domestic government funding share**

   a. **Economic advocacy**[14]

      - Calculate economic benefits of TB control and develop related advocacy materials.
      - Test use of advocacy materials and evaluate results.
      - Disseminate advocacy materials nationwide and conduct training in their use as part of ACSM training

   b. **District health planning and budgeting**[15]

      - Identify and review any ongoing or planned work by the government or development organizations;
      - Depending on results of review, work with other organizations to develop and implement evidence-based planning and budgeting capacity for all health needs and advocacy capacity.
      - Analyze the sources and uses of health resources in the ten planning and budgeting pilot districts[16] and in one current MDR-TB district.
      - Provide guidance to MOH and partners to develop advocacy materials and tools and methodologies so they can roll them out to all districts.

   c. **TB planning and budgeting**

      - Conduct evaluation to determine effectiveness of previous planning and budgeting training
      - Follow-on the pilot training in planning and budgeting conducted in 10 districts in Jawa Tengah Province. Add an additional district that provides MDR-TB services.
      - Analyze the sources and uses of TB resources.
      - Use their existing plans and budgets (with the addition of MDR-TB) together with baseline financial analysis and advocacy materials to improve health

[14] A first draft of a scope of work is shown in Annex 3.
[15] A first draft of a scope of work is shown in Annex 4.
[16] These districts are in Central Java and will form part of the MDR-TB expansion plan.

allocations to TB. (This will be combined with the cost-effectiveness analysis activity proposed in Activity 5.)
- Using baseline data received through the ACSM finance monitoring activity, identify districts with exceptionally high and low allocations to TB, and conduct remote interviews to identify reasons.
- Evaluate process and results
- Roll out to other districts.

3. Element 2: Revenue generation

a. Insurance

- Review government policies and plans for insurance for health in general and for TB in particular.
- Assist NTP to negotiate expansion of insurance coverage for TB.
- Review district revenue generation performance and potential for insurance funding.
- Develop materials and strengthen capacity to improve claiming.
- Test and roll out materials and capacity.

b. Local donations

- Develop and disseminate planning and advocacy materials for attracting donations from corporate social responsibility schemes and train district TB managers how to use them.

4. Cost-effectiveness and efficiency

a. Review cost-effectiveness and efficiency as part of planning and budgeting process (including MDR-TB diagnosis and treatment and patient incentives).
b. Carry out an in-depth study of projected costs for all TB costs in one district using GeneXpert and providing MDR-TB treatments in general and in the prison system.
c. Identify areas where costs can be saved and develop interventions to achieve them.
d. Develop materials and strengthen capacity to analyze and improve cost-effectiveness and efficiency.

General Approach

To reach the goal of having 80% of the TB funding come from Indonesian sources will require interventions in all of above areas - advocacy, planning and budgeting, generation of local non-government funds and cost-effectiveness and efficiency.

Due to the complexity of some of the interventions, the need to determine which combinations of interventions will be most successful, and the size of the country, it will probably take 3 to 4 years to develop, test and roll out all these elements of the package.

It will be necessary to strengthen local capacity to do this work early on in the process to reduce technical dependency on international organizations during and after the project.

Capacity building

As stated above capacity building will be an important aspect of this work. Firstly, the technical assistance team will need to work closely with relevant counterparts in the central NTP[17]. Secondly, we will develop and use simple tools and methodologies that can be easily translated and transferred and we will train people who can then train others. Thirdly, most of the training and implementation work around the planning and budgeting and related district finance analysis will be done through a local staff, consultants and/or an organization, probably one of the universities.

Monitoring and evaluation

Since achieving the goal of the exit strategy will involve several interventions over time and progress will undoubtedly vary across the country it will be important to have a good monitoring and evaluation system. There should be several elements to the system. The first involves the collection of TB finance data for all districts to measure overall achievement of exit strategy[18]. The second will be the collection of additional finance data from a number of sentinel districts for more in-depth analysis. And the third will be the close monitoring of interventions and impact in pilot districts.

Coordination

Sustainability is an issue for several key health programs, not just TB. It will be necessary to coordinate strategies and interventions with those responsible for other major donor-assisted programs, such as HIV/AIDS and malaria and with provinces and districts to see what exit strategies they have. It is also necessary to co-ordination interventions with other government bodies and with other major donors, such as the Australian Agency for International Development (AusAID).

Incentives and agreements

Complementary interventions that can be considered are the use of incentives and agreements. Incentives can include the use of matching funds or awards/recognition for districts that achieve financial targets. Agreements such as Memoranda of Understanding can also be used between donors/central government and local governments.

[17] We recommend that the NTP hire a person with finance skills to serve as a full time counterpart for this work. By working together with that person we can strengthen his/her skills.
[18] This activity is already being developed by KNCV.

6.0 SUPPORTING ACTIVITIES

Next steps

1. Assist NTP to develop an implementation plan for the exit strategy.
2. Develop a timeline for implementation activities to fit with the government planning and budgeting cycle.
3. Engage TB CARE I local project health finance staff to work on sustainability activities.
4. Encourage the NTP to hire local health finance staff as counterparts so that we can train them from early on.
5. Review report and all proposed activities with TORG.
6. Form working group – including NTP, Bappedas, Parliament, non-governmental organizations.
7. Review detailed scope of work for economic advocacy study (Annex 3).
8. Review SOW, develop a Request for Application, and engage an organization for the follow-on work on planning and budgeting in Central Java (first draft of SOW is shown in Annex 4).
9. Develop plan and scope of work for in-depth study of projected costs for a district using GeneXpert and providing MDR-TB treatments in general and in the prison system.
10. Develop plan and scope of work for revenue generation.
11. Gather baseline district data and interview a sample of districts with exceptionally high and low allocation levels to try to determine key factors (ACSM).
12. Identify related donor activities (e.g. AUSAID) and review the use of Australia debt relief
13. Coordinate exit strategy with MOH teams and partners working on other exit strategies.

ANNEXES

Annex 1: Original Detailed Scope of Work

1. Purpose of Proposed Visit:
The purpose of this visit is two-fold:

- to facilitate a workshop to review the Indonesia version of the WHO STOP TB Planning and Budgeting Tool and to prepare a plan for rolling out the tool to provincial and district levels, and ;

- to design and start the data collection for a study of the economic cost/benefit of controlling TB.

2. **Scope of work**

A strong health care system is necessary for the TB program to operate efficiently and effectively. In Indonesia, the local health system is still weak, especially the shortage of skilled human resources due to staff shortages and a training backlog. This results in poor surveillance, weak national and local health information systems, inadequate surveillance for TB in hospitals and private sector, and constraints in management of TB drugs/ laboratory supplies leading to stock outs.

Local ownership and effective planning and budgeting of health services and TB prevention and care are vital for success in order that adequate human and fianncial resources are provided. More work and new approaches are needed to engage policy/decision-makers to achieve greater ownership and commitment of resources. While there are susbstantial external funds for health programs, it is critical that the central and local government increase the provision of its own resources for TB, both in terms of assuming greater responsibility for the programs but also for their sustainability. It is also important that planning and budgeting skills and systems be improved so that the required resources can be correctly estimated so that adequate funding is sought.

To accomplish these objectives the consultant will work with the NTP and other counterparts as well as partners to carry out the following activities:

- lead a workshop to review the Indonesia version of the WHO STOP TB Planning and Budgeting Tool including reviewing the results of previous piloting, and prepare a plan for rolling out the tool to provincial and district levels.

- design and start the data collection for a study of the economic cost/benefit of controlling TB.

The first working day of the visit (Monday) will be used for discussions with project and NTP teams. The workshop will be held on the Tuesday and Wednesday of the first week. The balance of the time will be spent writing up the roll-out plan, designing the economic cost study and organizing data collection.

The actual roll-out of the tool and the implementation of the economic cost study will be carries out in APA 2 and supporting activities are being included in the APA 2 plan.

3. Outputs/Deliverables:

- Trip report
- Plan for rolling out the planning and budgeting tool throughout the country.
- Design protocol for the economic cost study.

4. Local support

It is anticipated that a local health finance consultant will be needed to assist with these tasks, including occasional interpretation and translation of technical documents.

Annex 2: Program of Events

September 13 – briefing meeting with NTP
September 15 – briefing meeting with USAID
September 21 – workshop on planning and budgeting tool
September 22 – workshop on economic benefit study
September 23 – debriefing meeting with NTP and partners
September 23 – debriefing meeting with USAID

Annex 3: Proposed scope of work for work on economic benefit analysis and advocacy

There are two main aspects to the work. The first is to calculate the economic benefits. The second is to develop the advocacy materials, test and disseminate them, conduct training in their use and evaluate the results. The dissemination should be completed in time to fit with the preparation of the district multi-sectoral and health plans for 2013.

Economic benefits study plan

1. Review international research and methodologies and determine scope and limitations of study.
2. Analyze work done in 2005 by Prof Ascobat Gani (University of Indonesia).
3. Determine which costs should be included (e.g., drugs, tests, direct staff, facility operating costs?)
4. Extract TB control cost figures from 2010 national TB planning/budgeting exercise and determine what additional cost data are needed.
5. Get NTP estimates for numbers of productive days lost.
6. Get figures for minimum daily wage for each province and calculate average.
7. Develop and populate simple spreadsheet model for analysis.
8. Review findings with NTP, TORG, members of working group and USAID.
9. Develop simple guide for using model.
10. Conduct training in use of model.

Advocacy

1. Develop materials based on results of economic cost/benefit findings
2. Test use of advocacy materials and evaluate results
3. Disseminate advocacy materials nationwide and conduct training in their use as part of ACSM training
4. Monitor and evaluate use of advocacy materials as part of the overall sustainability package of activities.

Annex 4: Proposed scope of work for expansion of planning and budgeting work

The recommended tasks for this activity can be divided into 2 sections: consolidation of the pilots and are as follows. The roll out of the planning and budgeting should be completed in time to fit with the preparation of the district multi-sectoral and health plans for 2013.

Conduct second phase of piloting in 10 districts in Central Java.

1. Conduct evaluation to determine effectiveness of the previous pilot planning and budgeting training in 10 districts in Central Java.
2. Update and complete, if necessary, the plans and budgets prepared as part of the pilot training for those 10 districts.
3. Conduct a sources and uses analysis of district health[19] and TB financing for 2010 for those 10 districts (an expansion of the baseline data collected for all districts). Include survey on how and why funds are allocated.
4. Use the health plans and budgets together with baseline financial analysis to develop information and materials for the district government to advocate for more funding for health.
5. Use the TB plans and budgets together with baseline financial analysis to develop information and materials for the TB program to advocate for more funding for TB.
6. Evaluate process and results.
7. Develop standard package of analysis, planning and budgeting and advocacy materials.

Roll-out

1. Using baseline data, identify districts with exceptionally high and low allocations to TB and conduct remote interviews to identify reasons.
2. Select high priority districts for roll-out based on allocations.
3. Disseminate materials and conduct training at provincial workshops.
4. Evaluate implementation of planning and budgeting in a sample of districts.

Additional

1. Collect baseline data on district allocations to TB for whole country (KNCV work plan)
2. If possible, collect same financial data from 7 districts studied in 2006 and compare with 2006 data.

[19] If no other organization is doing this.

Annex 5: Persons contacted

NAME	TITLE/ORGANIZATION
Dr Dyah Erti Mustikawati	NTP Director
Dr Nani Rizkiyati	Chief of Standardization Section NTP
Dr Budhiarti Setyaningsih	NTP Planning Unit
Dr Siti Anisah	NTP Human Resources
Yoana Anandita	NTP ASCM
Dr Bayu Teja M	Planning Bureau, MOH
Prastuti Soewondo	Public Health Faculty, University of Indonesia
Dr Nugroho Soeharno	Public Health Faculty, University of Indonesia
Nenden Siti Aminah	NTP ACSM
Dr Devi Yuliastanti	NTP ACSM
Ibu Retno Budiati	NTP TORG
Bp Surjana	NTP TORG
Dr Salim Hamid	KNCV Director
Setiawan Jati Laksono	KNCV Deputy Director
Endah Ramadhinie	KNCV
Dr Asik Surya	Chief of Monitoring & Evalution and Technical Assistants
Irene Koek	USAID/Indonesia - Director, Office of Health
Mary Linehan	USAID/Indonesia - Office of Health
Antoinette Tomasek	USAID/Indonesia - Office of Health
Kendra Chittenden	USAID/Indonesia - Office of Health
Candyana Yohan	USAID/Indonesia - Office of Health
Jeffrey Muschell	USAID/Indonesia - Office of Health
Russ Vogel	JSI/Indonesia
Rob Timmons	RTI/Indonesia

Annex 6: Proposed technical assistance time line for 2012

ACTIVITY	WHEN	TARGET
1. Help develop implementation plan for NTP exit strategy (in Boston)	Nov-Dec 2011	Draft plan
2. Conduct the study of the economic impact of preventing and treating TB and prepare advocacy materials	Jan-Mar 2012	Completed study and advocacy materials
3. Evaluate use of the Planning and Budgeting tool results in Central Java and review planning, budgeting systems and skills. Review of sources and uses of health and TB funds. Develop and test advocacy materials.	Jan-Mar 2012	Analysis of financing in 10 districts and advocacy materials completed.
4. Analyze cost-effectiveness and develop cost projections for new diagnostics and MDR-TB treatment in one district.	Jan-Jun 2012	Cost model and projections completed
5. Prepare package of planning, budgeting and advocacy materials for roll out by NTP and conduct Training of Trainers workshops for rolling out to other provinces and districts. Plan roll-out in more detail.	Apr-Jun 2012	Package prepared, ToT conducted and roll-out plan prepared.
6. Assist with analysis and planning of insurance financing	Jan-Sep 2012	Analysis and plan prepared
7. Assist with development of corporate social responsibility plan and advocacy materials	Apr-Jun 2012	Analysis and plan prepared
8. Monitor and analyze district financing data (KNCV)	Ongoing	Ongoing
9. Engage local health finance staff and award sub-grant to local university to assist with above.	Jan 2012	Staff hired and sub-grant awarded