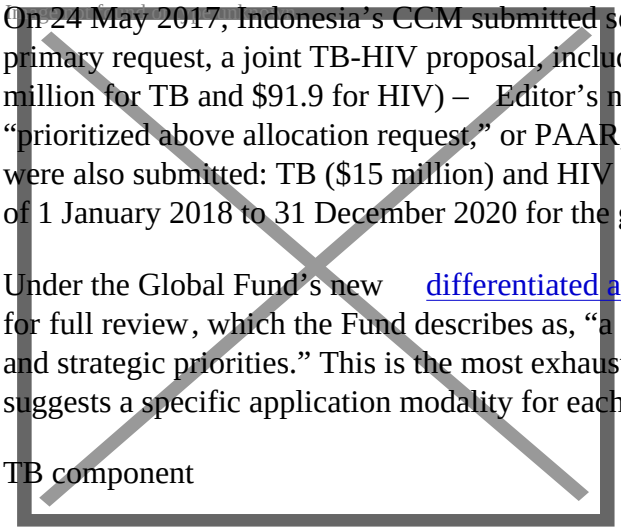
INDONESIA'S FUNDING REQUESTS TO THE GLOBAL FUND PRIORITIZE FINDING MISSING TB CASES, HIV PREVENTION SERVICES FOR KEY POPULATIONS

On 24 May 2017, Indonesia's CCM submitted several funding requests (FRs) to the Global Fund. The primary request, a joint TB-HIV proposal, included a within-allocation request of $195.8 million ($104.3 million for TB and $91.9 for HIV) – Editor's note: There is a problem with the math in the FR – and a "prioritized above allocation request," or PAAR, of $80.7 million. Two associated matching funds requests were also submitted: TB ($15 million) and HIV ($2 million). The CCM proposed an implementation period of 1 January 2018 to 31 December 2020 for the grants emanating from these FRs.

Under the Global Fund's new differentiated application process, the joint TB-HIV request was submitted for full review, which the Fund describes as, "a comprehensive overall review of a program's approach and strategic priorities." This is the most exhaustive type of application in the new process. The Fund suggests a specific application modality for each country in its allocation letters.



TB component

According to the FR, "The national TB program requires a paradigm shift and an acceleration approach which will set it 'back on track' to achieve its national strategic targets as well as the global benchmarks the country committed to." The TB component is based on the revised National Strategic Plan for TB Control 2016-2019; the TOSS TB strategy (a "test and treat"–like approach) launched in 2016; findings of the latest Epidemiological Review 2017 and TB Impact Modeling and Estimates (TIME Impact); and findings and recommendations of the Joint External Monitoring Mission from January 2017.

The FR describes several key contextual factors driving the TB response in Indonesia. One major factor is

persistent problems with case notification to the National TB Program (NTP). Recent epidemiological reviews suggest that up to 70% of the "missing TB cases" may actually be receiving care but are simply not reported to the NTP. Many care providers in Indonesia do not report TB cases to the NTP because they are "not linked up to the system" – often because they are private providers. About half of all TB patients in Indonesia who receive care obtain their care from "non-NTP providers."

This not only hampers national program planning, but also limits the Ministry of Health's ability to assess quality of care for many patients. The FR suggests that this is one reason for the procedural and paper work burden associated with reporting such cases. However, beginning in 2016, TB case reporting became mandatory for all providers, so as "to provide a stronger basis for engagement of the private sector in quality TB care and notification." But the change in regulations will not solve the notification issue on its own.

Another contextual factor is low multi-drug resistant TB (MDR-TB) diagnosis. Last year, the NTP only diagnosed 8% of the estimated 32,000 MDR-TB cases in Indonesia.

Finally, the FR describes a number of key and vulnerable populations for TB which require special attention in the TB response due to elevated risk or reduced access to services. These key populations include children, the elderly, the urban poor and people living with diabetes mellitus.

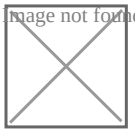
Based on these factors and lessons learned from the current 2016-2017 Global Fund grants, the NTP has revised its National Strategic Plan. "The key element of the revised strategy is the radical change from a centralized to a district-based approach," the FR said. This change is expected to improve diagnosis, notification and care for TB patients, including MDR-TB patients and TB patients living with HIV. A major thrust of the response will be, "a tiered geographic targeting strategy of TB and HIV interventions and service packages as a means of concentrating resources in locations where they will have the most impact."

Two TB-specific modules are proposed in the within-allocation FR: TB care and prevention and MDR-TB. Both modules aim to increase detection of missing cases, notification to the NTP, and to ensure that quality of care aligns with national standards. In addition, two TB/HIV modules are proposed: TB/HIV, which encourages greater coordination between the two disease programs at the national and sub-national levels, and Programs to reduce human rights-related barriers to TB & HIV services, which provides support for building community capacity to prevent, document and respond to human rights crises in the context of TB and HIV. Another module, RSSH, includes a range of interventions to strengthen the HIV and TB responses through community and health systems.

HIV component

Recent epidemiological modeling estimates that about 63% of new HIV infections in Indonesia are among key affected populations (KAPs), while 64% of people living with HIV overall are "non-KAP." Among KAPs it is believed that HIV incidence has stabilized and begun to decrease – except among men who have sex with men (MSM), who are experiencing increasing HIV incidence. This modeling also suggests that with current levels of intervention, overall HIV incidence will remain flat at 40,000-50,000 new cases annually, until 2030, with MSM making up an increasing portion of those new cases over time (see figure). The ineffectiveness of current approaches to produce a net decrease in HIV incidence for KAPs is thus a major driver of the epidemic in Indonesia, according to the FR.

Figure: Estimated and Projected Annual Number of New HIV Infections, 1990-2030



Source: TB, HIV and RSSH Funding request from Indonesia, 24 May 2017

Another driver, as described in the FR, is low HIV treatment coverage. "Indonesia lags behind other countries in the

region in terms of antiretroviral therapy (ART) coverage, the FR says. “While some success has been achieved in increasing the number of persons on ART (reaching nearly 78,000 by the end of 2016), the most recent ‘cascade’ data available indicate that further progress is needed.” The “cascade” refers to the numbers of people living with HIV who are diagnosed, enrolled in care, on treatment, and virally suppressed. In most countries, the number decreases in each category, creating a visual ‘cascade’ effect on charts, depicting fewer and fewer people receiving services or achieving a clinically positive outcome.

Other key contextual factors in the HIV response described in the FR include under-utilization of available services; lagging outcomes in prevention of mother-to-child transmission (PMTCT) and pediatric HIV treatment; persistent stigma and discrimination against key populations and people living with HIV; and a “deteriorating enabling environment.” The deteriorating environment is primarily evidenced by a widespread crackdown on sex work and sex workers, the emergence of a government-endorsed anti-LGBT movement, and a continued campaign against people who inject drugs, according to the FR.

While domestic financing for HIV has been steadily increasing –12% annually between 2009 and 2014 – this funding is directed primarily to HIV treatment and care. Very limited domestic resources are allocated to prevention programs for key populations and none is targeted to civil society organizations. In response to this gap, the HIV component of the proposed Global Fund grant focuses on KAP prevention and civil society and community systems.

The HIV programs proposed in the FR are intended to accelerate progress toward the achievement of National HIV and AIDS Strategic Plan targets, the UNAIDS 90-90-90 targets, and the overall goal of “ending HIV and AIDS in Indonesia by 2030.” To do so, actions will be taken at each stage of the cascade, all with a primary focus on key populations.

The interventions proposed in the within allocation and PAAR requests aim to provide treatment for 215,000 people living with HIV; provide 10.7 million HIV tests; and increase prevention service coverage for key populations, using “innovative approaches” (see table).

Table: Proposed KAP prevention coverage target increases

KAP	2016 coverage (actual)	2020 coverage (proposed)
Transgender people	48%	72%
Men who have sex with men	58%	90%
Female sex workers	60%	90%
People who inject drugs	57%	59%

The foundation of the HIV component is shared with TB: the tiered geographic targeting of interventions. This is functionally a devolution of HIV services to various sub-national districts. Built on this foundation are eight HIV-specific modules, in addition to the TB/HIV modules discussed above. Four of the eight modules are prevention programs for key populations (MSM, transgender people, sex workers and their clients, and people who inject drugs). A fifth key population, “people in prisons and other closed settings,” is addressed with a prevention, testing and treatment module. The remaining modules – PMTCT, HIV testing, and treatment, care and support – address other factors impacting Indonesia’s overall treatment coverage and treatment cascade.

Funding landscape, co-financing, and sustainability

Full review and tailored funding requests require applicants to describe factors related to the overall funding landscape, domestic co-financing of the relevant disease responses, and program sustainability, which refers to the financing of programs if and when Global Fund support is no longer available.

Domestic financing for TB and HIV in Indonesia has grown, and this is projected to continue over the next funding cycle. The contribution of domestic funding to TB has risen to $52 million in 2017, representing a 70% increase over recent levels, and domestic financing for HIV is projected to grow from $69.3 million in 2017 to $85.5 million in

2020, an increase of 23.4%, according to the FR. One of the main contributors to domestic financing growth of late has been the establishment of the National Social Health Insurance program, which is described in the FR as the largest single-payer health insurance program in the world. But despite this growth in spending, the FR notes that domestic funding for health as a percentage of GDP remains comparatively low. And while the government of Indonesia has signaled its intent to fully finance its HIV and TB responses, "No clear timetable has been communicated."

The domestic increases are generally positive news, as such increases are central to the Fund's idea of program sustainability. But the fact that Indonesia today has an allocation from the Global Fund of nearly $200 million suggests that the country is a long way from transitioning away from Fund support. Thus, discussions of complete self-funding are not terribly advanced.

Matching funds

As indicated at the start of this article, the Indonesia CCM also submitted two matching funds requests. The Global Fund specified not only the dollar ceiling for each request, but also the strategic priority to be addressed. (For more information on matching funds and other catalytic investments, see articles in GFO 300, GFO 303, and GFO 309.)

The TB matching funds request of $15 million is for "Finding missing TB cases." The request, which reflects the full amount available, builds on the $30 million in the within-allocation request for this same priority.

The strategic priority indicated for the HIV matching funds is "Reducing human rights barriers." The matching funds offer as per the allocation letter is $2.7 million, whereas the amount requested is $2.0 million, reflecting the amount allocated for reducing human rights barriers in the main FR. The proposed interventions, as required, build on the relevant interventions in the main FR, and are aimed at reducing barriers to accessing HIV services among key populations, people living with HIV, and TB patients. The interventions aim to reduce stigma and discrimination among MSM and transgender people; improve legal literacy (also for MSM and transgender people); and improve laws, regulations and policies relating to HIV and HIV/TB.

Implementation arrangements

The funding request nominates the Ministry of Health, Aisyiyah (an Islamic women's NGO), and LKNU as principal recipients (PRs) for the TB component. The MOH and Aisyiyah are PRs for Indonesia's current TB grant. The LKNU, a new addition, is the health arm of a socio-religious Islamic organization. Both Aisyiyah and LKNU are civil society organizations. According to the FR, the second CSO PR (LKNU) was appointed to improve the performance of the CSOs and to help them develop a long-term role in TB control (i.e. until elimination is achieved).

The Ministry of Health, Spiritia Foundation (an HIV civil society organization), and the Indonesia AIDS Coalition are listed as PRs for the HIV component, a continuation of their roles with Indonesia's 2016-2017 HIV grant.

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