INDONESIA STRENGTHENING NATIONAL TUBERCULOSIS RESPONSE

PROGRAM-FOR-RESULTS (PforR)

(P178517)

DRAFT

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT REPORT (ESSA)

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PREPARED BY THE WORLD BANK

ABBREVIATIONS AND GLOSSARY

TERM	EXPANDED TERM/ DEFINITION
AIDS	Acquired Immune Deficiency Syndrome
AMDAL	Environmental Impact Assessment
APCASO	Asia Pacific Council of AIDS Service Organization
BKPK	Board for Health Policy
BOK	Health Operational Fund or *Biaya Operasional Kesehatan*
BPJS-K	National Health Insurance Agency or *Badan Pengelola Jaminan Sosial Kesehatan*
BSSN	National Cyber and Crypto Agency
COVID-19	Corona Virus Disease 2019
DG	Directorate General
DHO	District Health Offices
DLI	Disbursement Linked Indicator
DPPM	District Based Public Private Mix
E&S	Environmental and Social
EHS	Environment Health and Safety
ESSA	Environmental and Social System Assessment
FGRM	Feedback and Grievance Redressed Mechanism
FY	Financial Year
GIIP	Good International Industry Practice
GOI	Government of Indonesia
HIV	Human Immunodeficiency Virus
HWM	Hazardous Waste Management
I-SPHERE	Indonesia – Supporting Primary Health Care Reform Program
ICT	Information Communication Technology
ILO	International Labor Organization
IPC	Infection Prevention Control
ISO	International Organization for Standardization
Jamsostek	Labor insurance
JKN	National Health Insurance
KARS	Hospital Accreditation Commission or *Komisi Akreditasi Rumah Sakit*
KKI	Indonesian Medical Council
KOPI TB	Medical Professional Association for Tuberculosis in Indonesia
MDR	Multi-drugs resistance
MENKES	Ministry of Health or *Kementerian Kesehatan* (same as MOH)
MKDKI	Medical Disciplinary Board of Indonesia or *Majelis Kehormatan Disiplin Kedokteran Indonesia*
MOEC	Ministry of Education and Culture
MOEF	Minister of Environment and Forestry

MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOL	Ministry of Labour
MOU	Memorandum of Understanding
NAR	New-All Record
NDA	Non-Disclosure Agreement
NGO	Non-Government Organization
NTP	National TB Program
OHS	Occupational Health and Safety
PAP	Program Action Plan
PAP	Program Action Plan
PDO	Program Development Objective
PERPRES	Presidential Regulation
PforR	Program-for-Results
PFR	Program-for-Results same as PforR
PHO	Provincial Health Offices
POP TB	TB Patient Association
PPE	Personal Protective Equipment
PPM	Public Private Mix
PR	Primary Recipient
Pusjak PDKI	Centre for Health Financing and Decentralization
Puskesmas	Public primary health centers
RA	Results Area
SITB	Information System for Tuberculosis
SOP	Standard operation procedure
SR	Sub-Recipient
SSR	Sub-Sub-Recipient
STPI	Stop Tuberculosis Partnership Indonesia
TB	Tuberculosis
TBD	To Be Determined
TBPS	Tuberculosis Private Sector
TCLP	Toxicity Characteristic Leaching Procedure
TCM	Rapid Molecular Testing or *Tes Cepat Molekuler*
UKL-UPL	Environmental Management Efforts and Monitoring Efforts
USAID	United States Agency for International Development
WBG	World Bank Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

1. **This Environmental and Social Systems Assessment (ESSA) report has been prepared for the World Bank's the World Bank's Indonesia Strengthening National Tuberculosis Response Program-for-Results (PforR) (P178517).** The ESSA process examines the environmental and social management systems that are applicable to the proposed PforR to assess their compliance with the Bank Policy on PforR Financing. It aims to ensure that the program's environmental and social risks will be managed adequately and that it complies with the PforR core principles. The scope of the ESSA process includes an assessment of:
   a) potential environmental and social risks and benefits;
   b) environmental and social systems that apply to the program;
   c) implementation experience and capacity;
   d) whether system and performance are consistent with core principles of the Bank PforR Policy; and
   e) steps required to improve scope of system or capacity.

2. **The preparation of this ESSA report is based on a desktop information review and consultations undertaken at the central level**. Most of the consultations were conducted virtually between June and July 2022. Stakeholder groups consulted included relevant agencies within the implementing agencies, health facilities, civil society, and professional associations.

3. **The proposed Program Development Objective (PDO) of this operation is to improve coverage, quality and efficiency of tuberculosis services in Indonesia by strengthening subnational TB response and the engagement of private health providers, as well as enhancing digital system in TB.** The Program supports three results areas (RAs) that contribute to the PDO: (RA1) Strengthened Sub National Tuberculosis Response, (RA2) Strengthened TB care among private health providers, (RA3) Enhanced digital systems for Tuberculosis.

4. **Directorate of Communicable Disease Control under the Ministry of Health (MOH), within which the National Tuberculosis Program (NTP) is housed, holds the main responsibility for Program implementation.** Program activities will be implemented at national and subnational level. While the implementation of the national agenda to eliminate TB will require a multisectoral approach, by involving other ministries and government agencies, the PforR sets the boundary for activities within the purview of MOH and funded through the MOH budget. While broader risks were assessed under the ESSA, Program Action Plans (PAPs) for the environment and social management of this PforR will be intended for relevant departments within MOH responsible for Program implementation. While not directly benefitting from the Program, technical guidance issued by the MOH under the Program is expected to benefit non-MOH hospitals designated as TB referral hospitals and other non-referral hospitals, as well as primary health facilities (both public and private). Additional risk oversight measures by MOH for activities being implemented by other agencies and entities were also included as part of PAPs to the extent they are technically and financially feasible.

5. **MOH is currently implementing two World Bank-funded PforRs, namely the Indonesia – Supporting Primary Health Care Reform Program (I-SPHERE, P164277)**, which have operated for four years and largely focuses strengthening a primary health care accreditation system and the Indonesia Emergency Response to COVID19 Program (P173843), which focus on strengthening key aspects of Indonesia's emergency to the COVID19 outbreak systematically. The same institutional arrangement for I-SPHERE and Emergency Response to COVID19 outbreak is being proposed and hence the project will build on prior experience and capacities implementing the program.

6. **The overall environmental and social risk is assessed as Moderate**. The overall environmental and social outcome is expected to be positive. The Program is expected to strengthen health service system response and enhance GoI's capacity for case detection and investigation, including tracing, case finding, diagnosed and treated for TB to the broader population. In the longer-run, the PforR also seeks to promote further reform in Indonesia's health system and capacities. This program will mostly benefit the broader population and affected individuals from the early diagnosis and treatment. The Program is not anticipated to produce any outputs that may have adverse environmental and social consequences. Additionally, the Program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities. The Program is not anticipated to generate e-waste since the improvement of digital ecosystem is expected to utilize the currently available Information Communication Technology (ICT) equipment. There are no anticipated adverse impacts on land acquisition, natural habitats, sensitive areas, cultural heritage, Indigenous Peoples, natural resources, and/or assets or people's livelihoods.

7. **Environmental risk rating is Moderate associated with suboptimal medical waste management, Infection Prevention Control (IPC), and Occupational Health and Safety (OHS) risks.** While most of activities will take place in existing public primary health centers (*Puskesmas*) and General Practitioners clinics with the procedures and facilities to handle TB air contamination and medical waste are in place – the increasing volume of medical solid waste and wastewater and lack of proper implementation and supervision may increase the potential pollution risk to the environment as well as OHS risks to the healthcare workers and health and safety risks to the community/public visiting health facilities. There is also potential pollution risk to the environment if there will be any sputum collection activities outside health facilities. Mitigation of these environmental risks will be sought through standard procedures as required by GoI laws and regulations on infection prevention control measures, occupational health and safety, and medical waste management.

8. **The country's approach in hazardous waste management is built upon "cradle to grave" principle with a rigid manifest system to track the flow of waste from the generator to the disposal facility.** The hazardous waste management are govern by the Government Regulations No.101/2014 on Hazardous Waste Management (HWM). Medical hazardous waste management are specifically regulated in MOH Regulations 18/2020 regarding region-based medical waste management in health facilities, MOH Regulation No. 7/2019 on environmental health in hospitals regulates, MOH regulation No. 43/2013 on proper management of the clinical laboratory. Requirement on medical waste management is part of the hospital, clinics and laboratories accreditation criteria. The requirements prescribed in the key regulations are harmonized with the GIIP, including the provisions on waste identification, reduction, segregation, storage, transport, disposal and occupational health and safety for waste handler – with all requirements related to management of medical (hazardous) waste. However, there is uneven distribution of facilities to processed medical waste across Indonesia, where 55% of facilities to process medical waste is located in Java Island. The limited number and uneven presence of licensed facilities in Indonesia indicate areas of attention for the planning of additional facilities or alternatives for medical waste management and monitoring of medical waste generation and its management across health clinics and laboratories.

9. **Primary health facilities are allowed to provide x-ray services under strict requirements that currently limit most of primary health clinics in providing the service.** The MOH Regulation No 24/2020 on Clinical Radiology Services allows health facilities to provide x-ray services with sufficient facilities and human resources. While up to date the regulations limits most of primary health clinics

from providing x-ray services, the PfoR need to ensure the system to monitor the implementation of standardized requirement for x-ray installment and usage are in place.

10. **Law No. 36/2009 on Health and Government Regulation No. 50/2012 on Health and Safety Management require hospitals and other health care facilities govern and ensure the workers' safety and health by implementing an OHS management system.** MOH Regulation No. 66/2016 on Hospital's occupational health and safety provides specific guideline on how to implement the management system in hospitals which include OHS practices, waste management, mandatory training, availability of Personal Protective Equipment (PPE), among others. The requirements prescribed in this regulation are harmonized with relevant GIIP such as the WBG EHS Guidelines for healthcare facilities and WBG EHS General Guidelines for OHS. MOH Regulation No. 27/2017 on infection prevention and control which align with WHO publications related to infection prevention and control guidelines. MOH's guideline on IPC for TB include guideline for TB IPC 2019, that require implementation of contact tracing and investigation for health care workers and community health volunteer, guideline for Multi-drugs resistance (MDR) TB care in Indonesia 2020. The implementation of IPC to manage the OHS risks will heavily depend on availability of proper PPE for health care workers as well as community health volunteers. The MDR TB Guidelines include the requirement of the use of N95 masks for all health workers, that mandates the use of PPE for health workers and community health volunteers which to be provided by the associated puskesmas. However, the availability of PPE for community workers are varied and for some areas very limited hence often lead to re-use or sub-standard use of PPE. MDR TB guideline also prescribes annual TB screening for health workers and community health volunteers with limited monitoring on the implementation. Moreover, as community health volunteers are considered as volunteers and not as formal health workers, they are not protected by employment law or covered by labor insurance (Jamsostek). The PforR need to ensure the system to monitor availability of adequate PPE are in place, including for the community health volunteer. Additionally, implementation of periodic screening, training and capacity buildings on TB related IPC for health care workers and community health volunteer need to be monitored.

11. **Social risk rating is Moderate with consideration on risks related to Program's activities that are expected to increase case findings, contact tracing of close contacts, increase screening and number of people treated.** Social considerations focus on strengthening TB service system response that cover issues on equity of access for vulnerable peoples and underserved populations in accessing quality TB services, risk associated with social stigma from active contact tracing, and risk associated with data privacy associated with surveillance and contact tracing with potentials to increase social stigma. Active contact tracing without proper procedure from providers could lead to social issues to TB patients, particularly social stigma. There is risk on data security particularly related to individual consent for data sharing from the advance digitalization activities and data use that might lead to social stigmatization.

12. **The ESSA indicates that there are general limitations on the current TB program associated with social risks, which will likely impact the effectiveness of TB elimination program** as follows: a) lack of sufficient resources and constraints in TB testing to ensure equitable access for high quality TB services delivery from tracing, screening, diagnostics, to treatment in both public and private health facilities**;** b) Lack of specific strategy to target marginal and vulnerable population including for people with disability, ethnic minorities or indigenous population; c) Lack of contingency plan, public information and communication strategy to TB patients, families and health care providers that resulted in social stigma, discrimination, and confusion regarding data privacy.

13. **The national TB program defines vulnerable populations as those with the higher risk for TB infection, not necessarily to those with limited access to healthcare services.** Guidelines for the unreached population target those with HIV and living in prison as well as congregate settings, as a result, the national TB strategies including communication strategy does not include people with disabilities, live in very remote areas, Indigenous Peoples, and those who are not formally registered or transient populations. Lack of accessibility for health services likely stems from limited services available in rural and remote areas. While these issues reflect the whole running of the healthcare system in Indonesia, which the PforR is not being prepared to address, the MoH has acknowledged the importance of strengthening primary healthcare operating in rural and remote areas and strengthening the existing program interventions to improve access from diagnostic to drugs and completion of treatment through engaging private providers and use of community health workers to increase access for TB health services.

14. **GOI protect citizens rights to live free from stigma by Law No. 39/1999 regarding human rights, with specific measures to reduce stigma among TB patients and family members that are mandated by the Presidential Regulation No. 67/2021**. Inadequate information and awareness about the risk of TB infection as well as stigma may likely increase resistance to seek TB care. Healthcare providers are facing challenges with patients low understanding and mis-information about TB infection, prevention, and treatment. In the absence of adequate trainings, communication strategy that include risk communication aspects, monitoring the implementation of code of conduct among health care providers, temporary accommodation for patients and workers during their infectious phase, stigmatization and discrimination will be inevitable. Public information and training for health workers and community workers to specifically prevent stigma, discrimination and to inform patients about data sharing for contact tracing, to increase patients compliance for diagnostic and treatment, as well as to ensure public health safety, are considered limited. Community health workers or cadres that are required to sign a non-disclosure agreement for data confidentiality are limited to those in coordinator level, hence there are concerns about the quality of service provided and patients data safety as cadres are not obliged to ethical code of conducts. While trainings for health providers and community workers include interpersonal communication, risk communication strategy to prevent stigma and discrimination are yet to be available. Moreover, information about what to do and where to report when TB patients suffer from stigma and discrimination are not widely disseminated. This ESSA also recognize the important of the provisions of safe workplace environment for TB patients and health workers.

15. **The MOH has incorporated Non-Disclosure Agreement (NDA) and smart checking for data privacy and confidentiality in the Covid-19 Integrated Health Information System (New-All Record/NAR) and made it public.** Protection on of civil rights to privacy and private data is fragmented across regulations and no overarching law in existence for the purpose, with weak protection of individual rights to personal data. Up to date, Law for personal data protection is still in the process for implementation by the national parliament. While patients' rights for informed consent and data privacy is protected under Law on Health No. 36/2009, it can also be waived over public interests to prevent the spread of infectious disease in communities. Contact tracing and treatment monitoring for TB mainly involve community health volunteers, in which without proper information and consent for data sharing, patients are more likely to be reluctant to seek TB care. Learning from Covid-19 response, practice for data protection in health sector demonstrates recognizable progress. The MOH has incorporated Non-Disclosure Agreement (NDA) and smart checking for data privacy and confidentiality in the Covid-19 Integrated Health Information System (New-All Record/NAR) and made it public.

16. **There is no specific national policy and regulations, or procedure associated with Feedback and Grievance Redressed Mechanism (FGRM).** Each government agency or program and hospitals operates its own FGRM, which varying avenues and response mechanisms. Under the hospital accreditation system, such facility-level FGRM is subject to audit and assessment by KARS (Family and Patients' Rights under Hospital Accreditation Standards HPK 3). Grievance management is decentralized at the facility level, and the utilization among TB patients is very low if not non-existence. At the national level, the MOH operates *"Halo Kemkes"* or they can be contacted by email both of which are not specifically designed functions as a grievance mechanism by health care clients, no reporting or monitoring for grievance mechanism regarding TB health services but rather feedback on overall health administration. Most patient care related complaints are handled at the facility level. Existing MOH, District Health Offices (DHO) and Provincial Health Offices (PHO) mechanisms to address complaints may be loosely linked with improvements in the overall.

17. Based on the above findings and assessment of gaps in the current system applicable to the Program, a number of measures are proposed and to be agreed with implementing agencies as part of the Program Action Plan (PAP). **The proposed PAP for environmental and social management are below**:

Occupational Health and Safety:

PAP 1. Training manuals and cascade training to health facilities and health workers, including community health volunteers, for proper handling of TB suspects, confirmed cases, and testing specimens, including the proper usage of PPE (web-based training).

PAP 2. Conduct rapid assessment on current practice in the health facilities and laboratories in provisioning adequate number of PPE for health workers, health facilities and laboratories staff, and community health volunteers in relation to TB contact tracing, testing and treatment.

PAP 3. Periodic screening and testing for healthcare workers, health facility and laboratory staff, and community health volunteers responsible for direct handling of TB suspects, confirmed cases, and testing specimens.

PAP 4. Conduct rapid assessment on current compliance of standardized requirement for x-ray facilities in health facilities.

Medical Waste Management:

PAP 5. Nominate responsible staff from the MOH whom in coordination with the Minister of Environment and Forestry (MOEF) to advise health facilities in managing the expected increase of volume of medical waste for mass TB screening, including through:

a) Conduct rapid assessment on current capacity/practice in the health facilities and laboratories to manage medical waste and the expected volume of waste generated, including waste handling proper handling of sputum collection activities outside health facilities.

b) Advising health facilities on the alternatives to manage their wastes (in house and external services), support approval of agreed options and develop the necessary work instructions for these alternatives`. Based on agreed options for medical waste management jointly with the MOEF and/or POHs/DOHs, support procurement for goods/ equipment where needed, facilitate dialogue with third parties (waste transporters, cement kilns, landfills for ash disposal, and so on).

c) Providing training to health workers, health facilities and laboratories staff, and community health volunteers on the proper management of TB response wastes (web-based training).

Social Stigma:

PAP 6. Communication strategy on public health messaging and community outreach on TB related facts to reduce stigma, in coordination with media and civil society organizations.

Medical Consent and Data Privacy:

PAP 7. A protocol for communication to TB patients included in TB clinical guideline incorporating data protection measures and consent is developed and disseminated to health workers and facilities.

Patient's security and safety:

PAP 8. Strengthen the existing system that include National Commission for Patients' Safety to monitor patients' security and safety during consultation and treatment at health facilities, including on aspects related to Sexual, Exploitation & Abuse/ Sexual Harassment.

PAP 9. Increase awareness and develop protocol on safe workplace environment include aspects related to Sexual, Exploitation & Abuse/Sexual Harassment with reporting and incident handling mechanism.

Feedback and Grievance Mechanism:

PAP 10. Standard operation procedure (SOP) to enhance the existing public Feedback and FGRM for TB response in terms of their accessibility, credibility and level of response.

A BACKGROUND AND SCOPE

A.1 Program Description

1. **The proposed Program Development Objective (PDO) of this operation is to improve coverage, quality and efficiency of tuberculosis services in Indonesia by strengthening subnational TB response and the engagement of private health providers, as well as enhancing digital system in TB**. The Summary of Disbursement Linked Indicators (DLIs) for the Indonesia Strengthening National Tuberculosis Response PforR is presented in **ANNEX 5**. The PDO will be monitored through the following PDO level indicators:

   - Increased TB case detection/treatment rate (coverage, quality)
     a. Increased TB treatment success rate (quality, efficiency)
     b. Increased proportion of notified TB cases managed at primary care level (efficiency)
     c. Decreased delays in treatment initiation OR
     d. Loss of follow up of diagnosed cases to treatment – reduced share of TB cases diagnosed and not put on treatment) (quality, efficiency)
     e. Number of private primary care providers that use the relevant health information system to notify TB cases to the National TB Program (NTP) (coverage)
   - A functional, integrated information system linked to a citizen mobile health application is in place (efficiency, citizen engagement)

2. **Directorate of Communicable Disease Control under the Ministry of Health (MOH),** within which the NTP is housed, **holds the main responsibility for Program implementation.** The Bureau of Planning under the Secretary General of MOH, and the newly established Board for Health Policy (BKPK), especially one of its centers, the Center for Health Financing and Decentralization (Pusjak PDK) will play a key role in the design of the performance-based health operational fund (BOK). The Directorate for Pharmaceuticals has a significant role in the procurement of TB program drugs and commodities, especially for diagnostics, such as cartridges for the rapid molecular machines. Other unit that is involved in the NTP include the Directorate General (DG) of Health Services, especially those responsible for health facility readiness and quality of service at the primary and secondary level of care.

3. Program activities will be implemented at national and subnational level. While the implementation of the national agenda to eliminate TB will require a multisectoral approach, by involving other ministries and government agencies, the PforR sets the boundary for activities within the purview of MOH and funded through the MOH budget. The government program includes multisectoral as well as multi-agency implementation, and in-kind support from donors.

A.2 Program Boundaries and Activities

4. **The Program will focus on strengthening the GOI's national tuberculosis response by i) strengthening subnational TB response, ii) strengthening the engagement of private health providers; iii) enhancing digital systems in TB**. The NTP has ambitious targets to reduce incidence of new TB cases by 50 percent by 2025, and by 90 percent in 2030, by increasing case findings with outreach activities, undertaking contact tracing of close contacts and increased screening, and controlling identified risk factors. The

National TB Strategy for 2020 – 2024[1] also includes improved quality of TB case management to increase retention and compliance in treatment, strengthened engagement with private health providers and with the national social health insurance agency (*Badan Pengelola Jaminan Sosial Kesehatan* or BPJS-K), as well as improved linkages between diagnostic, notification, and treatment services. The use of digital technologies and simplification of the existing information system for TB will be a critical element to support the efforts to achieve the ambitious targets. The program boundary is defined along the following dimensions: i) Program focus; ii) the implementing agency with overall responsibility, and iii) duration. These three dimensions are defined as follows:

i. **Program focus**: The Program will focus on strengthening the GOI's national tuberculosis response by i) strengthening subnational TB response, ii) strengthening the engagement of private health providers; iii) enhancing digital systems in TB. The national TB strategy for 2020 – 2024 also includes improved quality of TB case management, strengthened engagement with private health providers and with the national social health insurance agency (*Badan Pengelola Jaminan Sosial Kesehatan* or BPJS-K), as well as improved linkages between diagnostic, notification, and treatment services, and the use of digital technologies and simplification of the existing information system for TB.
ii. **Implementing agency with overall responsibility**. The implementation of the national agenda to eliminate TB (the government program) will require a multisectoral approach, by involving other ministries and government agencies, the Program sets the boundary for activities within the purview of MOH.
iii. **Duration**. Supporting a defined period of reforms, innovation and coverage expansion in the period of 2022-2025.

Alignment between PforR Program with GOI program is shown below. A more detailed alignment is provided in **ANNEX 2**.

Table 1: Proposed Scope of the Program

Item	Government Program	Program supported by the PforR
Title	National TB Program	Indonesia Strengthening National Tuberculosis Response PforR
Objective	To accelerate GOI efforts in eliminating TB in 2030 and in eradicating TB in 2050	To improve coverage, quality and efficiency of TB services in Indonesia
Duration	2020 - 2024	2022 – 2025
Geographic coverage	All Indonesia	All Indonesia

[1] Ministry of Health. National TB Strategy 2020 – 2024. https://tbindonesia.or.id/wp-content/uploads/2021/06/NSP-TB-2020-2024-Ind_Final_-BAHASA.pdf

Item	Government Program	Program supported by the PforR
Results areas	• Strengthened program management for TB response that are responsive in National, Province, District, City and Health Facility level • Increased quality of TB services that centered in people's need • Increased access to TB services • Increased public demand and awareness on the important of TB control	• RA1: Strengthened Sub National Tuberculosis Response • RA2: Strengthened TB care among private health providers • RA3: Enhanced digital systems for Tuberculosis.
Overall Financing	**US$ 1.300 billion** (3 years)	**US$ 724 million**

5. The Program supports three results areas (RAs) that contribute to the PDO:

   - **Results Area 1: Strengthened Sub National Tuberculosis Response.** The focus of this RA is on the establishment of a subnational fiscal transfer mechanisms linked to performance on key indicators important for subnational tuberculosis response.
   - **Results Area 2: Strengthened TB care among private health providers**. The focus of this RA is to support and strengthen the ongoing initiatives to effectively engaging the private sector in providing services to TB patients. This RA will identify innovative approaches that help improve the engagement of private providers in primary care settings, facilitating access to their patients for the services available under the national TB program. This RA will also consider initiatives that may help improve the attention of hospitals to refer back uncomplicated TB patients for care at the primary care level, as well as to better track treatment completion for services directly administered by them.
   - **Results Area 3: Enhanced digital systems for TB.** The objective of this RA is to create a digital ecosystem for the TB program, aimed at minimizing the reporting burden while improving data availability to inform better equity, access and monitoring of the program. The ecosystem would use the patient's health record as a single point of integration that makes it possible to better track the patient journey, provide support to service delivery, minimize reporting burden, enable monitoring and verification systems, and also help with financial allocations and claim payments.

6. **The results chain of the Program is presented in Figure 1.** It summarizes the activities, intermediate outputs and results, and outcomes by RA.

Figure 1. Theory of Change

Source: World Bank. Program Appraisal Document on A Proposed Loan to The Republic of Indonesia for The Strengthening National Tuberculosis Response. 2022. Report Number: PCBASIC025910.

A.3 Scope and Approach of the ESSA

18. **The scope of the ESSA focuses on the current system capacities within the implementing agency in managing environmental and social risks associated with the Program.** Specific risks have been assessed in view of the six core principles and key planning elements of the PforR ESSA (refer **ANNEX 3**). Relevant risks within the proposed RA under the PforR include:
    a. Environmental pollution due to suboptimal management of medical solid waste and wastewater;
    b. OHS risks for medical workers in providing medical care for TB patients as well as community; health and safety risks related to potential TB exposure at health facilities that providing care for TB patients and from handling, transport, and disposal of medical waste;
    c. Public and community health and safety, including patients' safety;
    d. Data security particularly related to individual consent and data use that might lead to social stigmatization;
    e. Social stigma to TB patients and individual suspected of TB as well as healthcare providers and health facility staff;
    f. Equity of access issues related to the existing barriers that people face in accessing quality TB services, especially for vulnerable peoples and underserved populations including Indigenous Peoples to ensure an equitable access.

19. **The overall environmental and social outcome is expected to be positive.** The Program is expected to strengthen health service system response and enhance GoI's capacity for case detection and investigation, including tracing, case finding, diagnosed and treated for TB to the broader population.

In the longer-run, the PforR also seeks to promote further reform in Indonesia's health system and capacities. This program will mostly benefit the broader population and affected individuals from the early diagnosis and treatment. Activities and investments included under the proposed PforR TB Strengthening do not include hard infrastructure assets. The Program will not finance any construction works so ther are no anticipated adverse impacts on natural habitats, sensitive areas, cultural heritage, natural resources, and/or assets or people's livelihoods. Additionally, the information systems improvement and integration will be done utilizing the currently available Information Communication Technology (ICT) equipment thus e-waste generation is not anticipated.

20. In this ESSA context**, vulnerable groups are groups of potential beneficiaries covering disadvantage and vulnerable groups in terms of gender, demographic, social and economic status, including people that live in *3T* regions (frontier, outermost, and least-developed)**. The Global Plan to End TB 2016 – 2020 define key and vulnerable population for TB as the most vulnerable, underserved, and at-risk populations to develop TB infections. National TB control strategy in Indonesia mentioned several groups of having higher factors for TB infections and illness, including smokers, malnourished patients, Diabetes Mellitus patients, children (<15 years), elderly (> 65 years), people living with HIV and AIDS (PLHIV), people in the group of urban poor and congregate settings including prisoners and incarcerated populations, migrants, refugees, closed mining workers, boarding institutions, and indigenous populations.

21. **People with geographic, socio-cultural, and economic barriers, including vulnerable groups, may face accessibility and equity issues, that reflect overall developmental challenges in the country**. The ESSA acknowledged systematic barriers to participation amongst these groups, which include amongst others geographic remoteness, access to technology, and various socio-cultural, economic barriers, including social and religious norms which may prevent certain groups from participating. Gender inequalities may also exacerbate access to health services. These variables reflect overall challenges of the healthcare system in the country and may not be necessarily addressed through the interventions supported by the Program.

22. **An environmental and social risk screening was undertaken at the concept stage (refer** to **ANNEX 1).** The purpose of the screening is two-pronged. First, the screening is to confirm that there are no activities which meet the defined exclusion criteria included in the PforR in line with the Bank Guideline for the ESSA. Secondly, the screening established the initial scope of the ESSA.

23. **The ESSA is carried out in accordance with the Bank Policy and Bank Directive on PforR as well as the Bank Guidance on PforR Environmental and Social System Assessment (September 18, 2020).** The guidance sets out core principles and planning elements used to ensure that PforR operations are designed and implemented in a manner that maximizes potential environmental and social benefits while avoiding, minimizing or mitigating environmental and social harm.

24. **Following the initial screening, the system review was conducted using a two-step approach**:

    a. Identification of relevant systems that are pertinent to the ESSA will be addressed in **Section C** on Review of Policy, Regulatory, and Institutional Frameworks; and
    b. Analysis of the implementation of the systems, including capacity and enforcement of certain environmental and social measures which will be addressed in **Section D**.

25. **In undertaking the ESSA, a performance assessment was undertaken as part of the ESSA process to understand existing practices and challenges.** The assessment analysis looks at the current capacity

(including financial and staffing), authority, future outreach strategy, consultation and potential risk plan of the implementing agencies through looking at present regulations, references material, track records and online discussion with the related implementing agencies. The assessment was conducted using the available secondary data such as government documents and regulations, data from MoH, and relevant assessment document conducted by other parties. A series of in person and virtual consultations with relevant unit within the implementing agencies were conducted including to the NTP. Consultations and field visits to Puskesmas were conducted by project task team at the early project preparation stage on May to June 2022. Additionally, the ESSA team also conducted a consecutive consultation that were done virtually due to COVID-19 pandemic, as follows: communities and Non-Government Organizations (NGOs), medical professional associations, health care facilities. Detailed minutes of these in person as well as virtual meetings and workshops are appended in **ANNEX 4**).

26. **Capacity assessment of the implementing agencies for the management of environmental and social aspects** considers relevant elements within the existing broader systems and selection was based on the level of potential environmental risks and impacts as well as social considerations. The assessment focuses on the adequacy of the relevant systems, including implementation, capacity to provide technical guidance, monitoring and enforcement.

27. **The ESSA process enabled the identification of gaps in the documented systems and their implementation, enabling the development of specific actions for improving environmental and social performance (Section E) under the Program.** The actions outline measures to address environmental and social risks and impacts, when the actions are considered complete, as well as the timeframe, responsibility and resource requirements. The majority of the actions are focused on environmental risks that have been identified while the social aspect is focused on the effectiveness of the current systems to provide equitable access to marginalized groups, data security and social stigma, as well as to manage complaints public feedback.

B STAKEHOLDER ENGAGEMENT

28. **This section provides a summary of the engagement activities undertaken for the PforR and specifically for the ESSA, as well as future engagement activities for ESSA disclosure.** Stakeholder engagement will form part of the PforR implementation, particularly in multi-sectoral coordination and planning for TB response, the development and implementation of infection prevention control measures, engagement of private health facilities, public health communication strategies, which involves external agencies, media, and civil society organizations.

29. **ESSA Guidance Note does not mandate a particular approach to consultations and allows for significant flexibility in the methods used. Consultations for PforR can take many forms but does not necessarily need to be based on consultation in large public gathering. With the outbreak and spread of COVID-19, people may be mandated to exercise social distancing, and specifically to avoid public gathering to prevent and reduce the risk of virus transmission. This situation affects to the project's ability to broadly consult to relevant stakeholders.** Virtual consultations have been held in order to overcome the limitations on the level of the proposed direct engagement with stakeholders. Consultations and stakeholder feedback are an integral part of Bank operations and so rather than defer stakeholder engagement, virtual consultations have been designed to be fit for purpose. A series of virtual meetings were held with relevant agencies within MoH, NGOs, association, academics, and health facilities. The results of the consultations as described below, specifically with relevant implementing agencies, will be used to propose action plans under the ESSA to improve capacity of the systems in managing environmental and social aspects.

30. **Due to engagement limitations during the ESSA preparation, views of private health facilities and vulnerable groups were sought through engagement with professional association, advocacy groups and civil society organizations.** Vulnerable groups considered under the PforR include poor households, particularly those living in slum areas due to their lack of ability to exercise proper social distancing measures and dependence on the informal sector, people in rural and remote areas, including ethnic minorities or Indigenous Peoples, due to their limited access to healthcare services and other marginalized groups whose access to the formal healthcare system may be impeded to the existing discrimination in the health system. Through strengthening the overall GoI's TB response, the PforR is expected to benefit the entire population of 268 million and covering all 514 districts, particularly people who may have TB visiting hospitals and health facilities, the community at large, especially vulnerable and high-risk populations such as the elderly and those with chronic conditions, and health care providers who will be providing care to TB infected patients. Community views will also be captured as part of the PforR implementation, particularly through the Program's efforts to strengthen public communication and community outreach.

31. **Stakeholder groups consulted included relevant agencies within the implementing agencies, civil society and non-government representatives.** Details of the stakeholders consulted as part of the preparation are presented in Table 2.

Table 2: Stakeholders consulted in the preparation of the Program.

Stakeholder Group	Stakeholders
Government Stakeholders	
Central Government	Ministry of Health - Bureau of Planning - Data Center and Information / *Digital Transformation Office* - Directorate of Health Service Facility of Directorate General of Health Service - Directorate General of Community Health - Directorate of Environmental Health, Directorate General of Community Health - Directorate of Occupational Health and Sport, Directorate General of Community Health - Directorate of Communicable Disease Control, - The National Tuberculosis Program, Disease Control and Prevention, Directorate of Communicable Disease Control
Non-Government Stakeholders	
NGOs	- Stop TB Partnership Indonesia (STPI) – NGO in TB Indonesia working in private sector and government partnership - Konsorsium Penabulu STPI – Global Fund Primary Recipient NGO working on community-based intervention for Tuberculosis elimination
Association	- KOPI-TB, Medical Professional Association for Tuberculosis in Indonesia - POP TB Indonesia - TB Patient Association in Indonesia
Health Facilities	
Primary Care Providers	- Puskesmas - Community workers in Puskesmas

32. **The consultations indicate that there are general limitations on the current TB program, which will likely impact the effectiveness of TB elimination programs.** Key emerging concerns and issues from various consultation were related to: a) OHS risks to health workers, facilities' staffs, and community workers or volunteers with direct contact with TB patients due to lack of requisite PPE availability, limited testing capacities, and work safety assurance; b) lack of sufficient resources and constraints in TB testing to ensure equitable access for high quality TB services delivery from tracing, screening, diagnostics, to treatment in both public and private health facilities**;** c) Lack of specific strategy to target marginal and vulnerable population including for people with disability, ethnic minorities or indigenous population; d) Lack of contingency plan, public information and communication strategy to TB patients, families and health care providers that resulted in social stigma, discrimination, and confusion regarding data privacy. A complete documentation of the stakeholder consultations is appended in **ANNEX 4**. The findings of the consultation are analyzed and provided in the environmental and social considerations on **Section D**.

33. **ESSA consultations will continue as part of the PforR implementation.** As there were engagement limitations during the preparation, environmental and social actions recommended through the ESSA will be consulted continuously to relevant stakeholders during the Program implementation. The draft ESSA will be disclosed prior to appraisal and the final version will be disclosed prior to the Board approval.

C ENVIRONMENTAL AND SOCIAL RISK RATING

34. **The overall environmental and social risk rating is assessed as Moderate.** The overall environmental and social outcome is expected to be positive. The Program is expected to strengthen health service system response and enhance GoI's capacity for case detection and investigation, including tracing, case finding, diagnosed and treated for TB to the broader population. In the longer-run, the PforR also seeks to promote further reform in Indonesia's health system and capacities. This program will mostly benefit the broader population and affected individuals from the early diagnosis and treatment. The Program is not anticipated to produce any outputs that may have adverse environmental and social consequences. Additionally, the Program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities. There are no anticipated adverse impacts on natural habitats, sensitive areas, cultural heritage, Indigenous Peoples, natural resources, and/or assets or people's livelihoods.

35. **Environmental risk rating is Moderate associated with suboptimal medical waste management, IPC and OHS risks.** While most of activities will take place in existing *Puskesmas* and General Practitioners clinics with the procedures and facilities to handle TB air contamination and medical waste are in place – the increasing volume of medical solid waste and wastewater and lack of proper implementation and supervision may increase the potential pollution risk to the environment as well as OHS risks to the healthcare workers and health and safety risks to the community/public visiting health facilities. There is also potential pollution risk to the environment if there will be any sputum collection activities outside health facilities. Mitigation of these environmental risks will be sought through standard procedures as required by GoI laws and regulations on infection prevention control measures, occupational health and safety, and medical waste management. The Program is not anticipated to generate e-waste since the improvement of digital ecosystem is expected to utilize the currently available ICT equipment.

36. **Social risk rating is Moderate associated with social stigma, data privacy and equity of access**. Risks are related to Program's activities that are expected to increase case findings, contact tracing of close contacts, increase screening and number of people treated, and controlling identified risk factors. Active contact tracing without proper procedure from providers could lead to social issues to TB patients, particularly social stigma. Work safety procedures, interpersonal communication skills, psychosocial education training and respectful working environment for the healthcare providers and individuals suspected of TB is required to be included in the Program. There is risk on data security particularly related to individual consent for data sharing from the advance digitalization activities and data use that might lead to social stigmatization, and equity of access issues related to the existing barriers that people face in accessing quality TB services, especially for vulnerable peoples and underserved populations including Indigenous Peoples to ensure an equitable access. Data security procedures and digital solution from technical aspects will be incorporated in the Program. There are no anticipated adverse impacts on natural habitats, sensitive areas, cultural heritage, Indigenous Peoples, natural resources, and/or assets, including land or people's livelihoods.

D POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORKS

37. **The review of systems covers the current existing system to manage environmental and social risks associated with the PforR operations in response to the TB Program.** This section covers the review of the relevant policy, legal and regulatory frameworks. A summary of the institutional responsibilities is provided as they relate to environmental and social performance as part of the PforR activity implementation.

38. A summary of the review of pertinent policies, laws and regulations is presented in this subsection, while full analysis of the country's legal framework is appended in **ANNEX 6**. Further analysis on enforcement, capacity, as well as challenges, will be further elaborated in **Section D**.

D.1 Tuberculosis Management Framework

39. **The implementation of the Presidential Regulation 67/2021 leverages the commitment level for TB elimination at the national level and streamline multi-sectoral collaboration of various ministries and agencies from the central and sub-national level.** The Presidential Regulation 67/2021 strengthen legal basis for TB response in Indonesia. The regulation also mandates the formation of acceleration team for TB elimination that consists of multi-sector ministers and national head agencies, with MoH in charge of leading the planning, implementation and coordination of the nationwide TB response. The Coordinating Minister of Human Development and Culture, along with the Coordinating Minister of Politics, Law and Security as Coordinating Minister of Economics, was leading as the supervisor for the acceleration team and to report directly to the President.

40. **The Presidential Regulation 67/2021 strengthen GOI's ambitious target to eliminate TB in 2030 and is in line with the Health Minister Regulation 67/2016 and National Medium Term Development Plan 2020-2024.** The Health Minister Regulation 67/2016 on TB Control aim to eliminate TB in 2035 and to eradicate TB in 2050. In the National Development Medium Term Plan, GOI targets the TB incidence rate to be 190 cases per 100,000 people in 2024, from baseline of 319 cases per 100,000 people in 2017; and TB mortality rate to be 37 cases per 100,000 people in 2024 from 42 cases per 100,000 people in 2017. In the Presidential Decree 67/2021, GOI commits to eliminate TB in 2030 by reducing TB incidence rate to 65 cases per 100,000 people and TB mortality rate to 6 cases per 100,000 people.

41. **The National Strategy for TB Response in Indonesia 2020 – 2024, launched by the MOH in 2020, provides strategies, interventions and target activities to achieve Indonesia's ambitious target to eliminate TB.** The National Strategy for TB Response consists of six strategies: 1) Strengthening commitment and leadership of national and sub-national government; 2) Increasing access to high quality and patient centered TB services; 3) Optimizing promotion and preventions efforts, as well as TB prevention treatment; 4) Utilization of research and technology for TB response; 5) Increasing involvement of communities, partners and multisector stakeholders; and 6) Strengthening program management through health system strengthening. The National Strategy for TB response targets three group of population based on access to TB services: 1) people with TB or TB symptoms that has not access health services; 2) People with TB that has access to health services but yet diagnosed or reported as TB patients; 3) People reported as TB patients but yet to be treated. However, during the Covid-19 pandemic some of the funding for health programs, including for TB program, were repurposed to finance the Covid-19 response at the national and sub national level. Other health system resources, such as human resource for health, medical supplies, and equipment, were mobilized and hence stretched the existing capacity to deliver essential health services including that for TB.

42. **While the Covid-19 pandemic put the implementation of National Strategy for TB Response into some setbacks, the launched of the Presidential Regulation 67/2021 on TB response on August 2021 is expected to reverse the impact by increasing the priority to restore access to and provision of essential TB services.** The first year of pandemic has exacerbated the progress of TB treatment in the world. From 2019 to 2020, there was an 18% reduction of number of people newly diagnosed with TB, and Indonesia is one of the countries that mostly contribute to this decline. The pandemic also causes 15% reduction of the number of TB patients with drug resistance to receive treatment, and 21% reduction of people receiving TB preventive treatment.

43. **At the sub-national level, Provincial and District government play a dominant role to ensure the implementation of TB national strategy.** After more than two decades since the decentralization started, more than two-thirds of total public expenditures on health occurs at the subnational level; central government (i.e., the MOH) manages only about one-third of total public spending. The Health Minister Regulation 67/2016 mandates both national and sub-national government to responsible in TB response health service deliveries. The Presidential Regulation 67/2021 calls for more details measures to ensure TB health service deliveries in sub-national level, which also to provide funding for TB, to provide and increase human resources to ensure minimum standard operation for TB health service delivery are met, to do active case finding that involve society, to ensure TB reporting in the government system, to provide prevention treatment to high risk population, to mitigate psychosocial and economic impact in TB patients and families, and to implement policies to ensure patients TB are fully treated.

D.2 Environmental Consideration

D.2.1 Environmental pollution due to suboptimal management of medical solid waste and wastewater

44. **The country's approach in hazardous waste management is built upon "cradle to grave" principle with a rigid manifest system to track the flow of waste from the generator to the disposal facility.** The requirements prescribed in the key regulations are harmonized with the GIIP, including the provisions on waste identification, reduction, segregation, storage, transport, disposal and occupational health and safety for waste handler – with all activities to managing medical (hazardous) waste, including to store, transport, treat or dispose, require valid permit/license from relevant agencies.

45. Based on The Government Regulations No 66/2014 on Environmental Health, waste management **is part of the efforts to protect public health, in which waste management in health facilities, including clinics, laboratories and hospitals, must comply with the related Minister Regulations**. The country's main framework on hazardous waste management is cast in Government Regulations No.101/2014 regarding Hazardous Waste Management, whereas the specific regulations on medical waste management in health care facilities settings are prescribed in MOH Regulations 18/2020 regarding region-based medical waste management in health facilities. While the MOH Regulation 7/2019 regarding environmental health in hospitals regulates specific measures for waste management in hospitals level, and MOH regulation No. 43/2013 regarding proper management of the clinical laboratory mandates specific measures for waste management in laboratories. **Requirement on medical waste management is part of the hospital, clinics and laboratories accreditation criteria.** The MOH makes it mandatory for all hospitals to get accredited by an independent accreditation body every three years, as well for Bio-safety level-2 (BSL-2) laboratory accreditation requirements. The primary health care accreditation, which include medical waste, are required for all Puskesmas and clinics and regulated in MOH Regulations 46/2015. In spite of the above regulations on medical waste

management both in hospital, other health facilities and laboratories, the PforR need to ensure the system to monitor the medical waste generation and proper management specifically related to TB Program implementation are in place. The system will need to include proper handling of sputum collection activities outside health facilities.

46. **Standards on wastewater effluent from healthcare facilities in Indonesia is comparable with the GIIP**. MOH regulation No.7/2019 outlines the requirement to manage the wastewater from healthcare facilities, this includes the requirement to have wastewater treatment plant, conduct routine effluent monitoring, meet the effluent threshold requirements and report the monitoring to relevant government agencies. The effluent standard from the wastewater treatment plant prescribed in the MOEF regulation No. 5/2014 on the wastewater effluent standard. The threshold set in the regulation is comparable with the performance standard set in WBG Environment Health and Safety (EHS) Guideline for healthcare facilities (performance indicators for wastewater). MOEF Regulation No. 56/2015 requires wastewater from incinerators to comply with MOE regulation No. 5/2014.

47. **Primary health facilities are allowed to provide x-ray services under strict requirements that currently limit most of primary health clinics in providing the service**. Nuclear Energy Regulatory Agency Regulation No. 4/2020 regarding radiation safety on the use of x-ray machine in diagnostic and interventional radiology prescribes the requirements for radiation safety for all licensed x-ray user for diagnostic and interventional radiology. The requirements include aspects on management, protection from radiation, technical, and safety verification. This regulation prescribes requirements for x-ray license owner to provide protection toward radiation in workplace and to patients as well as healthcare facilities visitors. It also requires staffs that provides x-rays services to have health screening provided by the health facilities. Exposure to x-ray for patients must be justified with clinical indications, previous exposure, the benefit from having x-ray, dose appropriateness, and patient's conditions. Moreover, The MOH Regulation No 24/2020 on Clinical Radiology Services allows health facilities to provide x-ray services with sufficient facilities and human resources, including doctor specialized in radiology, radiographer, radiation protection and administration staff. Primary health services are limited to provide radiology services that include the use of mobile x-ray machine, dental x-ray and ultrasonography. The regulation also prescribes the standard requirement for having x-ray services from the building facilities to the providers' organization, service provided, monitoring and reporting, as well as quality control and assurance. While up to date the regulations limits most of primary health clinics from providing x-ray services, the PfoR need to ensure the system to monitor the implementation of standardized requirement for x-ray installment and usage are in place.

D.2.2 OHS risks for medical workers and public health safety

48. **GOI laws and regulations mandate every workplace to implement OHS management system**. Law No. 13/2003 on workforce (article 35) protects workers in general by mandating employer to protect worker's well-being, safety, physical and mental health. Law No. 36/2009 on Health (section XII) and Government Regulation No. 50/2012 on Health and Safety Management require hospitals and other health care facilities to oversee and ensure the workers' safety and health by implementing an OHS management system. Moreover, MOH Regulation No. 66/2016 on Hospital's occupational health and safety provides specific guideline on how to implement the management system in hospitals, which include risk management, OHS practices, waste management, fire prevention, mandatory immunization for workers, mandatory training, availability of PPE, among others. The requirements prescribed in this regulation are harmonized with relevant GIIP such as the WBG EHS Guidelines for healthcare facilities and WBG EHS General Guidelines for OHS.

49. **To ensure occupational health safety and infection prevention to health care workers in health facilities, MOH issued regulation No. 27/2017 on infection prevention and control, which align with WHO publications related to infection prevention and control guidelines.** The regulation covers detail building construction requirement, zoning guideline, safe practices, appropriate PPE for workers, among others. The requirements prescribed in the regulation address the guideline issued by WHO on key OHS considerations for health workers. Similar requirements on OHS and infection prevention and control in the hospitals are included as criteria for hospitals accreditation. MOH regulation No. 43/2013 regarding Proper management of clinical laboratory provides comparable requirements to ensure OHS management in laboratories is also in line with WHO's laboratory biosafety guidance.

50. **Director General Decree on Health Services No 01.07/I/4596/2021 provides technical guidelines for infection prevention and control for drugs-sensitive and multi-drugs-resistance TB in health facilities**. Efforts to provide TB IPC in congregate settings include implementation Technical Guidelines for TB Infection Prevention Control in prisons by Minister of Law and Human Rights, which prescribed regulation, planning, education and information and standard ventilations. However, requirements to ensure implementation, like that in the accreditation process for health care facilities are not in place. National Strategy for TB Control calls for efforts to strengthen IPC that include revision for TB IPC 2012 guideline , trainings and capacity buildings for health care workers, periodic screening for healthcare providers, public education, multi-sector collaborations for IPC in communities including in houses, boardings, prisons and workplaces. MOH has launched a revised TB IPC guidelines in 2019 specifically to IPC requirements in implementation of contact tracing and investigation for health care workers and community health volunteer. MOH has also launched guideline for MDR TB care in Indonesia in 2020 that prescribed IPC specifically for MDR TB in health facilities.

51. **Regulation on IPC not only protect health care workers but also patients and visitors of health care facilities.** MOH Regulation No. 66/2016 on hospitals occupational health and safety and MOH Regulation No. 27/2017 on infection prevention and control cover health care workers, patients and visitors of the hospitals. MOH Regulation No. 27/2017 also mandates basic requirements on facility location, building standards, ancillary facilities (laboratory, blood banks, temporary waste storage), disinfection and sterilization of equipment, sanitation services, staff competency and monitoring and evaluation to ensure the health and safety of patients, especially to prevent nosocomial infections at the facility. Moreover, MOEF Decree No 56/2015 regarding Procedures and Technical Requirements of Hazardous Waste Management from Health Care Facilities prescribes the requirement for hazardous waste storage location to protect the safety of patients and visitors. Further, specific criteria in hospital and primary care facilities accreditation have also included the provision to ensure patient and visitor health and safety.

52. **The implementation of IPC to manage the OHS risks will heavily depend on availability of proper PPE for health care workers as well as community health volunteer**. The PforR need to ensure the system to monitor availability of adequate PPE are in place, including for the community health volunteer. Additionally, implementation of periodic screening and training and capacity buildings on TB related IPC for health care workers and community health volunteer need to be monitored.

D.3 Social Consideration

53. This section covers assessment on existing Indonesia' policy and regulations on equitable access related to the existing barriers that people face in accessing quality TB services, especially for vulnerable peoples and underserved populations, including ethnic minorities or Indigenous Peoples, social stigma to TB patients and individual suspected of TB associated with unproper procedure from

health providers, data security particularly related to individual consent and data use that might lead to social stigmatization, and stakeholder engagement through public information dissemination and FGRM.

D.3.1 Equitable of access issues related to the existing barriers that people face in accessing quality TB services, especially for vulnerable peoples to ensure an equitable access

54. **Citizen rights to have equal opportunity to access healthcare and safety in protection from all forms of discrimination, are fully protected by Law.** The Constitution of 1945 Article 28 A and Health Law No. 36/2009 guarantees the rights of all Indonesian citizens to have equal opportunity to health, including to access healthcare that are safe, high quality and affordable. Through its constitution and Law, GOI guarantees the protection of citizens' rights to be align with human rights, gender equality, non-discriminative, and equity principles. Based on Law No. 8/1999 on Consumer Protection, all citizens have the rights to choose health services, to be treated without discrimination, to have access to information regarding services, to be heard, to be treated with fairness and have legal access to litigation. The law also protected access to health services for people with disabilities, in which health care providers must ensure that health services and facilities are accessible and non-discriminatory. Patients and families should have access to information regarding illness, treatment, prognosis and alternative treatment regardless of request for information.

55. **GOI protects TB patients' and their family members' rights to access to health services, to get psycho-social and economic protection that are equitable to vulnerable population and non-discriminatory, however the implementation needs further commitment and supports from other non-health Minister and Agencies.** The Presidential Regulation No. 67/2021 calls national and sub-national government to ensure that TB patients and family members to have access to health and social protection, to non-discriminatory services, to have jobs security, to be included and empowered in taking part of the TB control programs. While specific TB drugs regimen for people with HIV/AIDS are included on MOH Decree No. HK 01.07/Menkes/755/2019 regarding clinical guideline for TB treatment, protocols or guidelines to target specific group listed as the high-risk and vulnerable population are lacking. Minister of Law and Human Rights launched Technical Guidelines for TB Infection Prevention Control in prisons, which prescribed regulation, planning, education and information and standard ventilations. However, requirements to ensure implementation, like that in the accreditation process for health care facilities are not in place.

56. **In the National TB Control Strategy and regulations, there are no specific interventions to ensure gender equality, to target people with disabilities and indigenous population included as part of TB Control program.** The MOH launched the National Strategy for TB Control that include specific strategies to reach high-risk and vulnerable population in TB who are defined as people with malnutrition, diabetic patients, elderly, people with HIV/AIDS, health care workers, and people living in congregate settings including prisons, urban slums, formal and informal workplace, mining sites, refugees camps, boarding school and Islamic boarding institutions. Decree of the Minister of Health No. 1278 / Menkes / SK / XII / 2009 on guidelines for implementing collaborative control of TB and HIV diseases calls for collaboration mechanism between TB and HIV/AIDS health services to increase access in that high-risk population. Rights for people with disability are protected under Law No. 8/2016 that include, among other things, rights to be free from stigma, for health, education, jobs, privacy, accessibility, and public services.

57. **GOI responsibilities to provide equitable and accessible health care to all Indonesian remains as a persistent challenge particularly in the easter-region of Indonesia.** Although the health sector supply

side readiness has improved over the years, but the disparities in the availability of quality health services remain. Health facility surveys conducted in 2011, 2016 and 2019 showed that the overall service readiness of public primary health facilities has improved. The rural-urban gap in Puskesmas' capacity to deliver services is decreasing but those in the eastern regions continue have lower capacity. The capacity to deliver basic health services also has been consistently better in the public sector compared to the private sector. The availability and distribution of human resources for health, however, also continues to be a challenge.

58. **All primary care clinics are required to provide TB services, while appointed hospitals are required to provide services for MDR-TB patients.** On MOH Law No 4/2019 regarding Technical Standard for Primary Care Quality Assurance on Minimum Health Services Standard, all primary care clinics must provide health services for TB. The MOH Decree No 350/2017 regarding Hospital and Health Care Providers for MDR-TB mandates 260 hospitals, mostly public hospitals, spread in 34 Provinces to provide health services for MDR TB. Up to November 2019, healthcare for MDR-TB patients are available in 233 hospitals and 1.988 satellite clinics

59. **TB diagnostic testing is available in majority of Puskesmas all over the country**. Distribution of diagnostic tests to all over Indonesia is part of the National Strategy for TB Control. On June 2022, there are 7,406 Molecular Testing with GeneXpert available in 1,781 health facilities, spread in 539 districts and cities in Indonesia, majority in Java, Sumatera, and Sulawesi. Up to 2021, simple microscopic testing for TB is available in 7,927 laboratories in Puskesmas.

60. **Although all fees and charges incurred for treatments of TB patients and people who may have TB at the government facilities are borne by the Government, most patients in the private healthcare must pay out of pocket.** As mandated by the Presidential Regulation 67/2021 and MOH Regulation 67/2016 in TB Control Tb drugs and diagnostics are available for no charge in all public health facilities and appointed private health facilities. However, in most private health facilities patients must pay for the TB treatment and diagnostics unless they are referred to public health facilities or to specific private health facilities appointed for providing multi drug resistance TB treatment by the government. While diagnostic capacity in private health facilities is limited and overall TB service readiness are low, a study in 2017 shows that 74 percent of people began seeking treatment for TB in private facilities. Nearly half of TB patients receiving private healthcare are paying out of pocket, at the risk of incurring catastrophic expenses which could push them to poverty. In public health facilities, TB treatment are paid through GoI's universal healthcare program (i.e. BPJS) and the National and sub-national government budget, which is consistent with the MOH Regulation No 67/2016. As TB drugs and diagnostics are procured by the central government and distributed at the sub-national level, it provides safety nets for those who may not be covered under the GoI's universal healthcare program (i.e. BPJS-K).

61. **Implementation of centrally produced national guidelines, standards and protocols at the sub national and health facility level throughout the country remains a challenge for ensuring continuity and quality of care.** Availability of human resources at puskesmas, district and provincial level to guide, supervise, and advocate for TB program implementation in public and private sectors remains limited. Private health facilities are facing challenges in providing high quality of care with sub-standard treatment. The Presidential Regulation 67/2021 calls for increasing the capacity of human resources in TB program, including to provide trained health workers in primary care, routine mapping of health workers, planning and budgeting training for TB health workers, and to ensure the integration of TB materials on all curriculums for healthcare providers. As an effort to increase quality of care, on-going

process for modification of payment system and health care payers (BPJS-K) to link health insurance payments and quality of TB care are in place.

D.3.2 Social stigma

62. **GOI protect citizens rights to live free from stigma by Law No. 39/1999 regarding human rights, with specific measures to reduce stigma among TB patients and family members that are mandated by the Presidential Regulation No. 67/2021**. Law No. 39/1999 Regarding Human Rights that calls for citizens' protection from all kinds of discrimination. Further, Presidential Regulation No.67/2021 mandates that all TB patients to be protected against stigma and discrimination. The regulation further state that efforts to prevent social stigma and discrimination is part of the communities role in the partnership with the government. The Presidential regulation calls for alignment and implementation of policy that will reduce stigma and discrimination among vulnerable and high-risk TB population. Further, MOH Regulation No. 67/2016 on TB Control calls for public participation in the TB elimination efforts by reducing stigma and discrimination of TB patients in the community. Mitigation efforts include providing health and social protections, to eliminate discriminations, to provide efforts that allow patients' independency, job security and inclusivity. However, up to date, the regulation for psychosocial support, economics and social protection, and patient protection from stigma as well as job security are yet to be implemented by the related Ministries and agencies, outside the Ministry of Health.

63. **While protection for job security in TB patients are protected by Law, that for discrimination among TB workers are not yet specified.** The Law No 13/2003 on workforce protects job security for TB patients by prohibiting employee termination due to sick absence less than twelve months in a row. MOH and Ministry of Labor (MOL) launched guideline for TB control in Workplace that requires implementation of directly observed treatment short-course measures in the workplace to ensure quality of care. In line with the Presidential Regulation No. 67/2021 that mandates job security for TB patients and family members and regulation for IPC on workplace, guideline for Tb control in workplace prescribed TB IPC measures and return to work programs for workers with TB. However, the current guideline for TB in workplace are yet to include measures on confidentiality, non-discrimination, gender equality, recognition of TB as workplace issues that are responded with bipartite approach, protection of the rights of workers that in line with principles of the ILO Code of Practice and the Occupational Diseases List (2010).

D.3.3 Data security on medical information particularly related to individual consent and data use that might lead to social stigmatization

64. **Protection on of civil rights to privacy and private data is fragmented across regulations and no overarching law in existence for the purpose, with weak protection of individual rights to personal data**. Indonesia has 32 laws and regulations which govern the protection of personal data/ privacy. Six of those are related to health sector include Law No. 29/2004 on Medical Practice, Law No. 36/2009 on Health, Law No 44/2009 on Hospital, Law No. 18/2014 on Mental Health, and Law No. 35/2009 on Narcotics. Up to date, Law for personal data protection is still in the process for implementation by the national parliament. Article 57 (2) of Law, No. 36/2009 on health, stated that exception on data protection could be made in several conditions include for public health interest by respecting the necessity and proportionality principles. Patients' data privacy and confidentiality are protected by Law No 36/2014 regarding Healthcare Providers article 73 and by Law No 44/2009 article 38 on Hospitals that mandates healthcare workers and hospitals to keep patients' data confidentiality. Further, Minister of Health Regulation No. 269/MenKes/Per/III/2008 on Medical Records and MOH

Regulations No. 36/2012 article 5 regarding patients' confidentiality stated that all health facilities must maintain the confidentiality of the patient's medical records except for extraordinary circumstances for health and safety reasons, law enforcement, at the request of the patient(s) concerned, and for research and education purpose without disclosing the patient's identity.

65. **Patients' rights for informed consent and data privacy is protected by Law and can be waived under several circumstances to protect public health.** While patients' rights for informed consent and data privacy is protected under Law on Health No. 36/2009 article 56-57, it can also be waived over public interests to prevent the spread of infectious disease in communities. This suggests that consent requirements for the purpose of tracing, testing and treatments for TB are not mandatory requirements. Under ordinary circumstances, protection of patients' confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek for the second opinion prevails prior to any medical treatment. Healthcare workers cannot be sued through any legal means in the context of emergency for life-saving treatments (Law on Health no.36/2009, Article 58, point 2).

66. **Private healthcare providers are required to share data of TB patients using MOH's data information system that must include patient's personal identity information**. District Based Public Private Mix (DPPM) is part of the National Strategy for TB Control to increase under-reporting of TB patients that are treated in private health services. Presidential Regulation No 16/2021 mandate every healthcare facility to report TB patients to district health office. Minister of Health Decree 660/2020 regarding Mandatory Reporting of TB Cases for Health Care Facilities mandates all healthcare providers to report TB cases using MOH's TB information system. District and Provincial Health Office are responsible for monitoring the reporting mandate, in which the result will be a considered for Special Allocation Fund by the central government. In reporting TB cases, health facilities are required to input patient's unique national identity code that are used to bridge information in the other health information system. Sub-national government are responsible to monitor the reporting. The national government use the result of TB reporting as consideration in providing special health fund allocation for the sub-national level.

67. **Rights for medical information are protected by Law No. 36/2009 on Health and Law No. 29/2004 on Medical Practice**. All citizens have the right to receive information and education about their health, including any intervention and medication. All healthcare providers must provide all medical information regarding patients' conditions, treatment options and its effect, and possible consequences related to patients' conditions.

68. **GOI allows patients' medical record to be electronic.** Government Regulation Article 17 and MOH Regulation No 269/2008 on Medical Record Article 2 allows medical record in the form of electronic. Current regulations mandate that electronic medical record to include patients' consent and full information about data usage, to be standardized with clear classification of open/closed data, to be stored in Indonesia, to be registered in the electronic system provider, to have ISO standard and certification. During the Covid-19 pandemic, the MOH developed and widely use PeduliLindungi application that partner with more than eighty applications, in which, to ensure patients data privacy, it applied the principles for data protection including full authority by the user to provide access to data to third party, that all private data are always kept in the application, unify color usage to prevent identification of any individual.

69. **As GOI is strengthening its health system using digital innovation with the usage of medical record, it must also strengthen its to ensure protection for patients' data privacy.** The Medium Term Development Plan 2020-2024 states that health system strengthening must be supported with

innovation and the use of technology. There are several Law and Regulation on personal data protection related to the use of electronic medical record, which include Law No. 11/2008 on Information and Electronic Transaction, Government Regulation No. 71/2019 on the Implementation of Electronic System and Transaction, Presidential Regulation No. 95/2018 Electronic Based Government System, Minister of Communication and Information Regulation No. 20/2016 on Data Privacy Protection on Electronic System, Law No. 36/2019 on Health, Law No. 9/2004 on Medical Practice, Law No 44/2009 on Hospitals, Government Regulation No 46/2014 on Health Information System. Law No.24/2013 on Citizenship Administration states that personal data that must be protected include information about physical or mental illness, fingerprint, iris of the eyes, signature, and other data that may create personal shame. Up to date, MOH is in the process to revise MOH Regulation No.269/2008 on Medical Record to add the principle of protection for data privacy in the electronic medical record. The revision shall include matters on data security, data protection, rights to access data, and authentication process to verify information.

D.3.4 Sexual Harassment Risks

70. GOI currently implemented Law No 12/2022 on Criminal Act towards Sexual Violence which include sanctions for any sexual harassment, with additional period of sanctions if the act was acted by health care providers. Article 15 on that Law specifically stated that criminal sanctions for sexual harassment or violence will be added by one third, if it was acted by health care providers, medical professional, education providers or professional which has the mandates to provide care, protection and rehabilitation. Moreover, protection for healthcare providers from sexual harassment and violence were implied in Law No 36/2014 on Health Workers (Article 57) that stated all health care providers have the rights to work in a safe and respectful working environment. The Law also stated that health care providers must oblige to code of ethics from each of the Medical Council, which have the obligations to investigate, process and decide on penalties if there's any complaints from the society which proof violations to the code of ethics.

D.3.5 Public Information Disclosure, and Feedback and Grievance Redressed Mechanism (FGRM)

71. **Under Law No. 14/2008 on Public Information and Law No 12/2005 on ratification for international covenant on civil and political rights mandate citizens' rights to access information and disclosure through public information is open and accessible by the public user other than exception information.** All citizen has right to understand public information, to attend public meeting, to get copy and to distribute them, except information considered as exception information. Dispute on public information will be solved in information court or dispute resolution negotiation and settlement by the Commission of Information. Detail explanation on type of information and exception, on unit that responsible for information openness and filing within each institution are regulate in various lower regulation such as the following below:

72. Government Regulation No.61 of 2010 in the implementation of the law, and institutions to implement the law (Information Commissions), Regulation of Information on Category of Information and information openness (all final public information produced by government is open unless it is formally classifying as secret);

    a. Regulation of Information Commission No. 1 of 2013 on conflict resolution on information;
    b. Regulation of Supreme Court No.2 of 2011 on conflict resolution on court procedure related public information;

c. Ministry of Education and Culture (MoEC) Regulation No. 16 of 2017 and No. 244 of 2015 on people who responsible and services related to information openness in MoEC. Information under MoEC should be filed and distributed under unit that specifically manage the information services in MoEC;
d. Ministry of Manpower Regulation No. 18 of 2012 on public information openness in Ministry of Manpower related to information organizing, service procedures and unit responsible for public information.

73. **The law and regulations above provide a legal basis for the Indonesia citizen to access information categorized as public information**, excluding exception information. Thus, information related to the Program is categorized as public information that should be open and accessible for all people by requesting from persons in charge in the information or through regularly disclose in in media. This law in practice is still not fully effective but this mainly is not related to the Program. The issue on public information disclosure in this Program is not relate to formal openness of the Program but relate more on how far the marginalized workers labor could naturally access the information, which will be discuss in institutional capacity section.

74. **There is no specific national policy and regulations, or procedure associated with FGRM.** Each government agency or program often has their own procedures of FGRM. Each hospital operates its own FGRM, which varying avenues and response mechanisms. Under the hospital accreditation system, such facility-level FGRM is subject to audit and assessment by KARS (Family and Patients' Rights under Hospital Accreditation Standards HPK 3). By law, patients have the option to file a lawsuit in court or to appeal to the Indonesian Medical Disciplinary Board (*Majelis Kehormatan Disiplin Kedokteran Indonesia*/MKDKI) (Law on Health No. 36/2009, Article 58, Law No. 8/1999 on Consumer Protection). The role of MOH in terms of addressing complaints tends to be on an ad- hoc basis, and the current operating FGRM platform (Halo Kemkes 1500-567, SMS 081281562620, fax (021)5223002, 52921669 and/or kontak@kemkes. go. id) is not specifically designed to address health-related grievances, but rather overall health administration.

75. **Under the current system, it is difficult for patients and families to charge medical professionals malpractices leading to injury, disabilities or even deaths under the criminal code (*Kitab Undang-Undang Hukum Pidana*).** Medical negligence and litigation implicating medical professionals (doctors and dentists) are investigated by the Indonesian MKDKI. The MKDKI is an autonomous body of the Indonesian Medical Council (KKI) and is authorized to issue testimony/statements with regards to negligence or mistakes or ethical issues in medical practices as well as remedial measures necessary including sanctions. Under these circumstances, the use of civil code (*Kitab Undang- Undang Hukum Perdata*) may be pursued, and complaints may be settled through financial compensation for improper services

D.4 Institutional Responsibilities

76. **The implementing agency for the Program is MOH, and the main unit responsible will be the Directorate of Communicable Disease Control, within which the NTP is housed.** The Bureau of Planning under the Secretary General of MOH, and the newly established Board for Health Policy (BKPK), especially one of its centers, the Pusjak PDK will play a key role in the design of the performance-based BOK. The Directorate for Pharmaceuticals has a significant role in the procurement of TB program drugs and commodities, especially for diagnostics, such as cartridges for the rapid molecular machines. Other units that are involved in the NTP include the DG of Health Services, especially those responsible for health facility readiness and quality of service at the primary and

secondary level of care. Data Center and Information is mainly responsible for the development and the use of digital technologies of the existing information system. As part of the stakeholder identification for the ESSA, key stakeholders are categorized as follows:

a. Category 1: Implementing stakeholders under the MOH, including NTP under the DG of Disease Prevention and Control, Bureau of Planning, DG of Health Services, DG of Public Health, DG of Pharmaceuticals, Center for Health Financing and Decentralization, as well as BPJS-K.

b. Category 2: External stakeholders contributing to the management of environmental and social aspects of the PforR.

c. Category 3: External stakeholders responsible for TB Control response as mandated by the Presidential Regulation 67/2021, where the PforR is part of. These include central government ministries, agencies, and sub-national government agencies.

77. **The current hierarchy and authorization of health care institution given the decentralized system**. The proposed PforR institutional arrangement takes cognizance of Indonesia's decentralized government system. The Indonesian system of government is devolved, with all three levels of government having significant responsibilities for health care and regulation of primary care health services. Within the decentralized health system, the relationships between MOH, PHOs, and DHOs is not a strictly hierarchical one, with each level having its own authority and mandates. PHOs and DHOs are under their respective provincial and district governments, which are under the Ministry of Home Affairs. MOH is responsible for the regulation of vertical hospitals, PHOs for provincial hospitals (both government and private-owned) and DHOs for district hospitals and clinics (both government and private-owned). However, there are still many roles retained by MOH in the context of TB control, such as providing technical guidance, establishing the regulatory framework, providing strategic interventions as well as monitoring and evaluation activities for the management of disease control.

78. **Target for the PAPs for the environment and social management.** While broader risks were assessed under the ESSA, PAPs for the environment and social management of this PforR will be intended for relevant departments within MOH responsible for Program implementation (i.e. stakeholders under Category 1). While not directly benefitting from the Program, technical guidance issued by the MOH under the Program is expected to benefit non-MOH hospitals designated as TB referral hospitals and other non-referral hospitals, as well as primary health facilities (both public and private). Additional risk oversight measures by MOH for activities being implemented by other agencies and entities were also included as part of PAPs to the extent they are technically and financially feasible.

79. The following table provides a summary of the institutional responsibilities with respect to the proposed PforR.

Table 3: Institutional Responsibilities for Environmental and Social Performance

Institutions	Institutional Responsibilities in TB Control	Institutional Responsibilities in PforR
Category 1: Implementing Stakeholders		
Bureau of Planning of MOH	Coordinate the planning of TB Control related logistics needs and activities from all relevant units within the MOH and develop a proposal that	Strengthened national TB response through subnational fiscal transfer mechanism

	reflects comprehensive needs for the health sector response. Facilitate NTP in requesting MOH Financial Year (FY) 2022 budget allocation to TB Control Provide guidance to the sub-national governments to reallocate the Central transfers (Special Allocation Funds for Hospital Infrastructure) for the TB Control program	linked with TB key performance indicators and improve coordination of financing at sub national and facility level. Coordinate and facilitate discussion between divisions in the MOH.
DG of Disease Prevention and Control of MOH, Sub Directorate TB (NTP)	Provide technical inputs related to disease control measures to NTP Provide technical guidance, including the formulation of technical policies/SOPs of disease control management to, and oversight and monitoring of the national and sub-national levels' response. Develop a workplan for disease control, especially surveillance, that includes detailed activities and logistics needs as inputs to the MOH overall emergency response plan.	Strengthen subnational TB response through subnational fiscal transfer mechanism linked with TB key performance indicators is implemented; and improve coordination of financing at sub national and facility level. Strengthen TB care among private primary care health providers by improving access to TB program drugs, diagnostics and strategic purchasing for TB services. Enhance digital system for TB via integrated TB transaction-based information system.
DG of Disease Prevention and Control of MOH, Directorate of Environmental Health	Provide technical inputs related to environmental health, including waste management, and occupational health for health workers to the MoH. Provide technical guidance, including the formulation of technical policies/SOPs on environmental and occupational health, and oversight and monitoring of the national and sub-national levels' response. Provide inputs on environmental and occupational health to the MOH's TB response plan.	Strengthen the capacity and availability of TB Control program as part of service delivery for basic services.
DG of Health Workforce	Provide policy, technical guidelines, evaluations and reporting for requirements, capacities, protections, and well-being of health workers	Monitor compliance in implementation of TB-related IPC for health workers and community health volunteers.
DG of Public Health of MOH, Directorate Health Promotion and Community Empowerment	Provide technical inputs related to the NTP regarding health messages and education material for the public	Provide strategic direction and implementation guidelines for public communication to prevent transmission of TB. It also provides oversight and monitor public health behaviour related to TB transmission

		Monitor complaints and grievances related to TB response.
DG for Pharmaceuticals Services	Provide technical inputs in the procurement of TB program drugs and commodities, especially for diagnostics, such as cartridges for the rapid molecular machines	Strengthen TB care among private primary care health providers by improving access to TB program drugs, diagnostics and strategic purchasing for TB services.
The Centre for Data and Information and the Digital Transformation Office	Provide technical inputs in the implementation and development of integrated TB transaction-based information system	Enhancing digital system for TB via integrated TB transaction-based information system.
Centre for Health Financing and Decentralization (Pusjak PDK), Board for Health Policy (BKPK)	Responsible for designing performance-based Health Operational Budget	Strengthen subnational Tb response through subnational fiscal transfer mechanism linked with TB key performance indicators is implemented; and improve coordination of financing at sub national and facility level
Category 2: External Stakeholders Contributing to Environmental and Social Management for the PforR		
MOEF	Issue permits for hazardous waste transportation and disposal, including for the handling of medical waste. Conduct audits on facilities' compliance on hazardous waste management and audit. Jointly worked with MOH to issue regulation related to public health and safety in the healthcare setting.	DG of Health Services of MOH will work in collaboration of MOEF in ensuring compliance of health facilities and laboratories on medical waste management.
National Health Insurance (BPJS-K)	Responsible for providing nation-wide social health insurance program with equity principle, to ensure that all members get the benefit from health services and protection in acquiring basic health needs	Provide TB utilization data recorded in BPJS-K. Include TB data in BPJS-K dashboard. Using its payment mechanism to support TB Control.
Provincial and/or District Environmental Agencies	Issue permits for hazardous waste facilities and oversight of the management of environmental aspects Conduct audits on facilities' compliance on hazardous waste management and audit in their province and/or district	DG of Health Services of MOH will develop standards and implementation guidelines in collaboration with MOEF as the national reference, and monitor and to provide oversight to ensure the compliance of provincial and/or district governments, especially through their environmental agencies in ensuring hazardous waste

		storage and incinerators in health facilities and laboratories.
Category 3: External stakeholders responsible for TB Control response as mandated by the Presidential Regulation 67/2021		
Ministry of Finance (MoF), Directorate General of Budget Financing and Risk Management	Develop a national-level fiscal policy and allocate budget for the health sector at the central and sub-national levels, and other fiscal measures to all affected sectors.	Allocate budget to ensure MOH have sufficient budget for PforR.
National Government acceleration team for TB control: ○ Coordinating Ministry for Human Development and Cultural Affairs ○ Coordinating Minister for Political, Legal and Security Affairs ○ Coordinating Minister for Economic Affairs ○ Ministry of Home Affairs (MoHA) ○ Ministry of Religious Affairs ○ Ministry of Law and Human Rights ○ Ministry of Education, Culture, Research and Technology ○ Ministry of Social Affairs ○ Ministry of Manpower ○ Ministry of Public Work and Public Housing ○ Ministry of Communication and Informatics ○ Ministry of Villages, Development of Disadvantaged Regions and Transmigration	○ Establish policies related to TB control; ○ Carry out integrated TB control activities; ○ Provide the necessary resources in TB control; ○ Mitigate the psychosocial and economic impacts faced by TB patients and ○ Their families; and ○ Carry out social protection and empowerment efforts for TB patients and communities affected by TB.	Not involved

○ Ministry of National Development Planning ○ Ministry of State-Owned Enterprises ○ Cabinet Secretary ○ Head of National Agency for Research and Innovation ○ National Agency of Drugs and Food Control		
Sub-national Government	○ Include TB in the regional medium-term development plan and regional government strategic plan as one of the health priorities in the region; ○ Coordinate the overall implementation of TB control activities in the region; ○ Provide funding for TB control activities from several sources; ○ Provide and improve human resources to achieve the target of minimum service standards related to TB control; ○ Carry out active and quick TB case finding by involving the community; ○ Ensure that all people diagnosed with TB are recorded and reported in the TB information system; ○ Provide TB preventive treatment to vulnerable populations; ○ Mitigate the psychosocial and economic impacts faced by TB patients and their families ○ Formulate and stipulate policies from governors and regents/mayors to encourage TB patients to carry out treatment until completion	Not involved

E INSTITUTIONAL CAPACITY AND PERFORMANCE ASSESSMENT

80. This section summarizes key findings or gaps on the assessment of system implementation, including the capacity of the relevant institutions to effectively implement the environmental and social management systems under the PforR. The review is conducted by assessing the current capacity and performance of the implementing agencies. The section also summarizes the extent to which the applicable systems are consistent with the key elements, as well as statements on the commitment of the relevant institutions to undertake measures to address the key gaps.

E.1 Environmental Considerations

81. **Environmental aspects that were assessed are based on the potential environmental risks in TB elimination program**. This includes potential risks associated with medical waste generated from testing of specimens and the treatment of TB patients and people who may have TB (suspect).

82. **Situation of medical waste treatment in Indonesia.** Medical waste treatment system in Indonesia is diverse in quality, with better services are concentrated in Java. According to the latest data from the MOH in December 2019[2] there are around 294.66 tons of hazardous waste produced each day from 2,820 hospitals and 9,884 community health centers (*Puskesmas)*, with an increased number of 383 tons/day in 2021. The Covid-19 pandemic has contributed to an increased medical waste generation of a total of 18,460 tons medical waste in June 2021 from Covid-19 cases treatment as well as vaccination activities. In 2021, there are 82 licensed incinerators and three licensed autoclaves across 20 out of 34 provinces, with the treatment capacity of around 493 tons/day. Although the capacity is still sufficient on paper, almost 55% of the incinerators and autoclaves are on the island of Java. Beside licensed incinerators and autoclaves, licensed cement kilns with a capacity of up to 248.88 tons of hazardous waste per day are available to process medical waste.[3]However, these kilns are located only in seven provinces, again, most of which are situated in Java Island. The limited number and uneven presence of licensed incinerators and cement kilns in Indonesia indicate areas of attention for the planning of additional facilities or alternatives for medical waste management. MOEF and MOH are partnering to improve the management of medical waste, including the availability of medical waste treatment, through an on-going medical waste management strategy. The strategy includes: i) short-term solution to treat the cumulation of medical wastes by processing it through cement kilns, ii) increasing the capacity of licensed third-party treatment facilities, iii) developing a 10-year roadmap of medical waste management, iv) developing an electronic instrument to monitor medical waste treatment from source to a disposal site, and v) construction of a region-based medical waste treatment facility (e.g. incinerator).

83. There are strict requirements on the management of medical incinerator ash (e.g. bottom ash, fly ash). MOEF regulation No. 56/2015 required all incinerator residue from medical waste treatment to be

[2] Data on licensed incinerators and autoclaves as well as the total waste generated from hospitals are taken from MOH presentation in a Webinar "Medical Waste Management During COVID-19 Pandemic" which was organized by Indonesia Hospital Association on April 1, 2020.

[3] Data on licensed thirdparty treatment facilities (cement kilns) is taken from MOEF presentation on "Hazardous Waste Management from Healthcare Facilities" dated March 12, 2020.

disposed to i) sanitary landfill, ii) controlled landfill, or iii) licensed hazardous waste landfill. For the disposal to sanitary and controlled landfill, the regulation requires the healthcare facilities to conduct pre-treatment to the wastes by encapsulation and ensures the pre- treatment product meets the stipulated toxicity characteristic leaching procedure (TCLP) standard. With the pre-treatment and TCLP test requirements, the disposal of incinerator ash to sanitary or controlled landfill might not be practical options. The disposal of incinerator ash to hazardous waste landfill could be a more practical alternative, as the healthcare facility can directly engage licensed third-party to manage it. However, there is only one licensed hazardous waste landfill in Indonesia, located in West Java Province.

84. **Potential risk for the medical waste treatment for the PforR to be implemented.** The increased number of patients with TB cases screened, tested and treated will resulted an increased volume of used PPE, specimen testing equipment, and other single-used medical equipment. There is also potential increased use of x-ray equipment for diagnostics, possibility for the procurement and instalment of x-ray in primary clinics. The current medical waste management in health facilities are following MOH Regulation 7/2019 on Environmental Health in Hospitals, MOH regulation No. 43/2013 regarding proper management of the clinical laboratory, and MOEF Decree No 56/2015 regarding Procedures and Technical Requirements of Hazardous Waste Management from Health Care Facilities. However, in consideration of uneven distribution of facilities to processed medical waste across Indonesia, a system needs to be in place to monitor the medical waste generation and proper management specifically related to TB Program implementation and to monitor the implementation of standardized requirement for x-ray installment and usage.

85. A strengthened TB response will also increase OHS risks among health workers and among community health volunteers with direct contact with TB patients. The OHS risks are mainly due to varied availability of PPE, in particular for smaller puskesmas and for community health volunteers. The technical guideline regarding multi-drug-resistance TB treatment include the requirement to use N95 mask for all health workers. While for the purpose of TB contact tracing, the guideline mandates the use of PPE for health workers and community health volunteers which to be provided by the associated puskesmas. However, the volume of PPE for community workers are varied and for some areas very limited hence often lead to re-use or sub-standard use of PPE. MDR TB guideline also prescribes annual TB screening for health workers and community health volunteers with limited monitoring on the implementation. Moreover, as community health volunteers are considered as volunteers and not as formal health workers, they are not protected by employment law or covered by labor insurance (*Jamsostek*).

E.2 Social Considerations

86. **Social aspects to be assessed were informed by the PforR towards strengthening TB elimination program.** The social considerations were:

    - Concerns related to equitable access for vulnerable population, including for people with disability, indigenous population, people living in remote and underserved area
    - Risks associated with data privacy associated with surveillance and contact tracing with potentials to increasing social stigma and marginalization for certain group
    - Risks associated with patient consent, grievance redress and the implementation of respectful working environment to ensure the safety of patients, health care providers and community workers or cadres

87. **Existing inequity in the healthcare system with implementation challenges in the current TB program may increase limitation in providing high quality TB services in both public and private sectors.** While GOI provide more access to molecular testing for TB diagnostics, the implementation are facing challenges with specimen transportation for referral and maintenance for the testing machine. From September 2021 to June 2022, from 973 gene-expert machine for TB diagnostic, owned by MOH, 354 are broken and 242 not yet repaired. The MOH's public private mix program, mainly focus on increasing the under reporting of TB cases in private facilities, are still facing challenges in increasing access for TB diagnostic and treatment in private hospitals and clinics. The complicated reporting mechanisms and inadequate financial incentive remain as the main cause of low motivation among private health facilities to provide comprehensive TB services.

88. **Strained healthcare capacities may likely challenge the ability of healthcare providers to implement proper consent processes as required by law**. Such a consent requirement is mandated under Law No. 29/2004 regarding Medical Practice. The law mandates the protection of confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek a second opinion. The provision may be waived in the name of public security to prevent further widespread of infectious diseases. Contact racing and treatment monitoring for TB mainly involve community cadres, in which without proper information and consent for data sharing, patients are more likely to be reluctant to seek TB care, questions the confidentiality of their health status when cadres involved and prone to stigmatization. Moreover, MoH's TB elimination program had not included public risk communication as one of the critical areas in anticipation of diagnostics and treatment refusal related to the disease.

89. **The national TB program has not included specific strategy to target marginal and vulnerable population but specifically towards the high risk population for TB infection**. The national TB program defines vulnerable population as those with the higher risk for TB infection, not necessarily to those with limited access to healthcare services. Guidelines for the unreached population target those with HIV and living in prison as well as congregate settings. As a result, the national TB strategies including communication strategy does not include people with disabilities or indigenous population. The national TB strategies for MDR-TB include enabler program, which provide financial support for all MDR-TB patients from diagnosis until patient finish his/her treatment, that aim to increase equitable access including for the marginal and vulnerable population.

90. **People with disabilities, live in very remote areas, Indigenous Peoples, and those who are not formally registered or transient populations (including nomadic, seafaring, farming communities, temporary and migrant workers) often lack access to health services, with no specific measures to target them in the TB program.** Lack of accessibility for health services likely stems from limited services available in rural and remote areas. TB drugs and treatment are provided by the MOH with no limitation to access despite the non-existence of ID card or proof of nationality. TB active case findings in the primary health facilities also increase service coverage among the marginal and vulnerable population. However, access for TB care may still be limited due to constraints in health infrastructure. While these issues reflect the whole running of the healthcare system in Indonesia, which the PforR is not being prepared to address, the MoH has acknowledged the importance of strengthening primary healthcare operating in rural and remote areas, as well as to engage private providers to increase access for TB health services. The PforR will address the issues of increasing coverage and access to TB care by strengthening the current scheme.

91. **Inadequate information and awareness about the risk of TB infection as well as stigma may likely increase resistance to seek TB care.** Patients and families refusal to access TB care are mainly related to low understanding of TB and stigma. In providing TB care, healthcare providers are facing challenges with patients low understanding and mis-information about TB infection, prevention, and treatment. Moreover, patients' self-stigma and family denials due to shame are most likely restrict them to access proper consultation and TB care that potentially furthering the spread of the disease.

92. **Stigma and discrimination against TB patients are being reported and mostly concerning in workplaces, education institutions, healthcare facilities and households**. People with TB are facing stigmatization and discrimination due to fears of infection by their closest contacts, and even by the healthcare providers. In the absence of adequate trainings, communication strategy that include risk communication aspects, monitoring the implementation of code of conduct among health care providers, temporary accommodation for patients and workers during their infectious phase, stigmatization and discrimination will be inevitable.

93. **Stigma, discrimination and confusion regarding patients data privacy remains a challenge, especially for patients with MDR TB, as training for the health and community workers are focusing on the medical aspects and information about TB.** Public information and training for health workers and community workers to specifically prevent stigma, discrimination and to inform patients about data sharing for contact tracing, to increase patients compliance for diagnostic and treatment, as well as to ensure public health safety, are considered limited. Community workers are require to sign a non-disclosure agreement for data confidentiality, however there are still concerns about the quality of service provided and patients data safety as volunteers are not obliged to ethical code of conducts. While trainings for health providers and community workers include interpersonal communication, risk communication strategy to prevent stigma and discrimination are yet to be available. Moreover, information about what to do and where to report when TB patients suffer from stigma and discrimination are not widely disseminated.

94. **Grievance management is decentralized at the facility level, and the utilization among TB patients is very low if not non-existence.** In general, MOH's ability to supervise how grievances are being handled has been a challenged, and currently there are no reporting or monitoring for grievance mechanism regarding TB health services. Under MOH, there is no centralized system addressing patient feedback and complaints. At the national level, the MOH operates *"Halo Kemkes"* or they can be contacted by email both of which are not specifically designed functions as a grievance mechanism by health care clients but rather feedback on overall health administration. Most patient care related complaints are handled at the facility level. Existing MOH, DHO and PHO mechanisms to address complaints may be loosely linked with improvements in the overall.

95. **The use of digital tools and communication that requires internet connection remains a challenge for rural and remote areas.** Many health facilities lack internet connection, which limits communication and adoption for digital. While the adoption of digital technology must consider these limitations, improved telecommunication technology and connectivity, present an opportunity to strengthen communication, increase access to information, including prevention measures and access to healthcare facilities and strengthen surveillance to increase effective tracing.

96. **Learning from Covid-19 response, practice for data protection in health sector demonstrates recognisable progress**. In the implementation of COVID-19 response MOH has incorporated NDA and smart checking for data privacy and confidentiality. The MOH has developed NAR guideline and made

it public through MOH's Data and Information Center in NAR website. Cyber-security protection as been supported by National Cyber and Crypto Agency (BSSN), with regular stress and penetration stress.

F ENVIRONMENTAL AND SOCIAL RECOMMENDATIONS AND ACTIONS

97. The following recommendations were made in light of **specific environmental and social risks identified during the preparation of the ESSA.** Further details of the recommendations are presented in **Table 4**.

98. **The recommended measures (on the following page) were shared in writing with MoH**. The draft ESSA report has been circulated with an executive summary in Bahasa Indonesia. A formal response has been received pertaining to the ESSA actions. Further consultation with MOH and relevant stakeholders is still being awaited to enable finalization of the environmental and social actions, which will form part of the PAPs.

99. **The World Bank will undertake periodic monitoring of the progress of the proposed environmental and social PAPs.** Such monitoring will be part of joint-regular implementation support missions between MOH and the World Bank and DLI verification processes by independent verifiers (i.e. Finance and Development Monitoring Agency or hereafter BPKP and KARS). Technical support for the implementation of the proposed action plans will be provided on a need basis.

Table 4: Environmental and Social Program Action Plans

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
Occupational Health and Safety							
1.	Training manuals and cascade training to health facilities and health workers, including community health volunteers, for proper handling of TB suspects, confirmed cases, and testing specimens, including the proper usage of PPE (web-based training)	Directorate of Occupational Health of the MOH and National Institute of Health Research and Development of the MOH	No	Yes	Every six months	On-going	Training manuals and number of e-training sessions delivered
2.	Conduct rapid assessment on current practice in the health facilities and laboratories in provisioning adequate number of PPE for health workers, health facilities and laboratories staff, and community health volunteers in relation to TB contact tracing, testing and treatment	Directorate of Occupational Health of the MOH and National Institute of Health Research and Development of the MOH	No	Yes	Every six months	On-going	Rapid assessments of health facilities and laboratories
3.	Periodic screening and testing for healthcare workers, health facility and laboratory staff, and community health volunteers responsible for direct handling of TB suspects, confirmed cases, and testing specimens.	Directorate General of Health Service of the MOH	No	Yes	Every six months	On-going	A guideline which prescribes periodic screening and testing for healthcare workers and facility staff has been developed; number of healthcare workers and facility staff screened and tested periodically.

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
4.	Conduct rapid assessment on current compliance of standardized requirement for x-ray facilities in health facilities	Directorate General of Health Service of the MOH	No	Yes	Annually	On-going	Rapid assessments of x-ray facilities in health facilities
Medical Waste Management							
5.	Nominate responsible staff from the MOH whom in coordination with the MOEF to advise health facilities in managing the expected increase of volume of medical waste for mass TB screening, including through:	Directorate Environmental Health of MoH	No	No	Within 3 months upon Program effectiveness and to be maintained throughout Program implementation	3 months upon Program effectiveness	Letters which indicate the nomination of responsible staff from MOH
	a. Conduct rapid assessment on current capacity/practice in the health facilities and laboratories to manage medical waste and the expected volume of waste generated, including waste handling proper handling of sputum collection activities outside health facilities.		No	Yes	Every six months	On-going	Rapid assessments of health facilities and laboratories
	b. Advising health facilities on the alternatives to manage their wastes (in house and external services), support approval of agreed options and develop the necessary work instructions for these alternatives. Based on agreed options for medical waste management jointly with the MOEF and/or POHs/DOHs, support procurement for goods/ equipment where needed, facilitate dialogue		No	Yes	Every six months	On-going	Administrative records

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	with third parties (waste transporters, cement kilns, landfills for ash disposal, and so on)						
	c. Providing training to health workers, health facilities and laboratories staff, and community health volunteers on the proper management of TB response wastes (web-based training).		No	Yes	Annually	On-going	Number of e-training sessions delivered; Number of participants in the e-training sessions.
Social Stigma							
6.	Communication strategy on public health messaging and community outreach on TB related facts to reduce stigma, in coordination with media and civil society organizations.	Directorate of Health Promotion Media: Bureau Communication and Public Service	No	Yes	Every six months	On-going	Nation-wide, using various mechanisms and channels. Include capacity buildings, monitoring and evaluation tools.
Medical Consent and Data Privacy							
7.	A protocol for communication to TB patients included in TB clinical guideline incorporating data protection measures and consent is developed and disseminated to health workers and facilities	Directorate of Referral Services Bureau Communication Public Service, Secretary General	No	Yes	Every six months	On-going	Clinical guideline with protocol for communication developed, disseminated and implemented.
Patient's security and safety							
8.	Strengthen the existing system that include National Commission for Patients' Safety to monitor patients' security and safety during consultation and treatment at health facilities, including on aspects	Directorate General of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services)	No	Yes	Every six months	On-going	Dissemination activities to ensure patients' security and safety

No.	Action	Responsibility	DLI	Recurrent	Frequency	Due Date	Completion Measures
	related to Sexual, Exploitation & Abuse/ Sexual Harassment.						
9.	Increase awareness and develop protocol on safe workplace environment include aspects related to Sexual, Exploitation & Abuse/Sexual Harassment with reporting and incident handling mechanism.	Directorate General of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services); Bureau Communication MOH	No	Yes	Every six months	On-going	Protocol for safe workplace environment developed, disseminated and implemented.
Feedback and Grievance Mechanism							
10.	SOP to enhance the existing public Feedback and FGRM for TB response in terms of their accessibility, credibility and level of response	Bureau Communication MOH; Directorate General of Health Service (Directorate of Health Facility and/or Directorate of Hospital Services)	No	Yes	Every six months	On-going	SOP developed and disseminated to relevant stakeholders

G. BIBLIOGRAPHY

Government of Indonesia. 2014. *Government Regulation No. 47 of 2014 on Health Information System.* Jakarta.

Government of Indonesia. 2021. *Presidential Regulation No. 67 of 2021 on Tuberculosis Control.* Jakarta.

Government of Indonesia . 2020. *Government Regulation No 18 of 2020 on Medium Term National Development Plan 2020 - 2024 Target.* Jakarta.

Government of Indonesia. 2014. *Government Regulation No. 101 of 2014 on Hazardous Waste Management.* Jakarta.

Government of Indonesia. 2012. *Government Regulation No. 50 of 2012 on Health and Safety Management.* Jakarta.

Government of Indonesia. 2018. *Government Regulation No. 95 of 2018 on the Implementation of Electronic System and Transaction.* Jakarta.

Government of Indonesia. 2018. *Presidential Regulation No. 95 on 2018 in Electronic Based Government System.* Jakarta.

House of Representative. 2003. *Law No. 13 of 2003 in Workforce.* Jakarta.

House of Representative. 2009. *Law No 36 of 2009 on Health.* Jakarta.

House of Representatives. 1999. "Law No. 39 on 1999 on Human Rights."

House of Representatives. 2004. *Law No. 29 of 2004 in Medical Practice.* Jakarta.

House of Representatives. 2009. *Law No. 44 of 2009 on Hospital.* Jakarta.

House of Representatives. 2014. *Law No. 18 of 2014 on Mental Health.* Jakarta.

House of Representatives. 2009. *Law No. 35 of 2009 on Narcotics.* Jakarta.

House of Representatives. 2016. *Law No. 8 of 2016 on Disability .* Jakarta.

House of Representatives. 2022. *Law No. 12 of 2022 on Criminal Act Towards Sexual Violance.* Jakarta.

House of Representatives. 2008. *Law No. 11 of 2008 on Information and Electronic Transaction.* Jakarta.

House of Representatives. 2013. *Law No. 24 of 2013 on Citizenship Administration.* Jakarta.

House of Representatives. 2008. *Law No. 14 of 2008 on Public Information.* Jakarta.

House of Representatives . 2015. *Law No. 15 of 2015 on Ratification for International Covenant on CIvil and Political Rights.* Jakarta.

House of Representatives. 2014. *Law No. 36 of 2014 on Health Workers.* Jakarta.

House of Representatives. 1999. *Law No.8 of 1999 on Consumer Protection.* Jakarta.

Lestari BW, McAllister S, Hadisoemarto PF, Afifah N, Jani ID, Murray M, van Crevel R, Hill PC, Alisjahbana B. 2020. "Patient pathways and delays to diagnosis and treatment of tuberculosis in an urban setting in Indonesia." *Lancet Reg Health West Pac.*

Ministry of Health . 2020. *National Strategy for TB Control in Indonesia 2020 – 2024.* Jakarta.

Ministry of Health . 2016. *Health Ministerial Regulation No 67 of 2016 on Tuberculosis Control.* Jakarta

Ministry of Health. 2019. *Ministerial Regulation No. 7 of 2019 on Environmental Health in Hospitals.* Jakarta.

Ministry of Health. 2020. *Ministerial Regulation No. 18 of 2020 on Territory Based Medical Based Waste Management in Health Facilities.* Jakarta.

Ministry of Health. 2013. *regulation No. 43 of 2013 on Proper Management of the Clinical Laboratory.* Jakarta.
Ministry of Health. 2015. *Ministerial of Health Regulation No.46 of 2015 on Accreditation for Puskesmas, Primary Clinic, Medical Doctor Private Clinic, and Dentist Private Clinic.* Jakarta.
Ministry of Environment and Forestry . 2015. *Minsiteria of Environment and Forestry Regulation No. 56 of 2015 on Hazardous Waste Management in Health Care Facilities.* Jakarta.
Ministry of Health. 2019. *Ministerial of Health Regulation No. 7 of 2019 on Environment Health in Hospital.* Jakarta.
Ministry of Environment and Forestry. 2015. *Ministrial of Environment and Forestry No. 56 of 2015 on Working Procdure and Technical Requirement for Waste Management.* Jakarta.
Minstry of Environment and Forestry. 2014. *Ministerial Environment and Forestry Regulation No. 5 of 2014 on Quality Assurance on Water Waste.* Jakarta.
Ministry of Health. 2020. *Ministerial Regulation No. 24 of 2020 on Clinical Radiology Services.* Jakarta.
Ministry of Health. 2016. *Ministerial Regulation No. 66 of 2016 on Hospital's Occupation Health and Safety.* Jakarta.
Ministry of Health. 2017. *Ministerial Health Regulation No. 27 of 2017 on Infection Prevention and Control.* Jakarta.
Ministry of Health. 2013. *Ministerial Health Regulation No. 43 of 2013 on Proper Management of Clinical Laboratory.* Jakarta.
Ministry of Health. 2021. *Directorate General Decree on Health Services No.01.07/I/4596/2021 on Technical Guidelines for Infection Prevention and Control for Drugs-Sensitive- and Multi-Drugs-Resistance TB in Health Facilities.* Jakarta.
Ministry of Manpower and Ministry of Health. 2015. *Guideline for Tuberculosis Control in Workplace.* Jakarta.
Ministry of Health. 2019. *Ministerial Decree HK. 01.07/MOH/755/2019 on Clinical Guidelines for TB treatments.* Jakarta.
Ministry of Health . 2009. *Ministerial Decreel No. 1278/MOH/SK/XII/2009 on Guidelines of Implementing Collaborative Control of TB and HIV.* Jakarta.
Ministry of Health . 2019. *Ministerial Regulation No.4 of 2019 on Technical Standard for Primary Care Quality Assurance on Minimum Health Services Standard.* Jakarta.
Ministry of Health. 2017. *Ministerial Decree No. 350 of 2017 on Hospital and Health Care Providers for MDR-TB .* Jakarta.
Minister of Health . 2012. *Ministerial of Health Regulation No. 36 of 2012 on Patients' Confidentiality.* Jakarta.
Ministry of Health . 2020. *Ministerial of Health Decree No. 660 of 2020 on Mandatory Reporting of TB Cases for Health Care Facilities.* Jakarta.
Ministry of Health. 2008. *Ministerial Regulation No. 269 of 2008 on Medical Record.* Jakarta.
Nuclear Energy Regulatory Agency . 2020. *Nuclear Energy Regulatory Agency Regulation No. 4 of 2020 on Radiation Safety on the Use of X-Ray Machine in Diagnostic and Interventional Radiology.* Jakarta.
Minister of Communication and Information. 2016. *Ministerial Regulation No. 20 of 2016 on Data Privacy Protection on Electronic System.* Jakarta.

Ministry of Health. 2020. *Directorate General for Health Services Decree on Technical Guideline for Sensitive Drug and Multi Drug Resistant TB Infection Prevention and Control.* Jakarta.
Ministry of Health. 2016. *Guidelines for National TB Control.* Jakarta.
Stop TB Partnership and Spiritia Foundation. 2020. *ocial Barriers to Accessing Quality TB Service: TB Key Populations, Legal Environment and Gender Assessment.* Jakarta.
Ministry of Health. 2019. *Ministry of Health. Technical Guideline for Contact Tracing for Health Workers and Cadres.* Jakarta.
World Health Organization. 2021. *Global Tuberculosis Report.* Geneva.

ANNEX 1. ENVIRONMENTAL AND SOCIAL INITIAL SCREENING

INDONESIA
Strengthening National Tuberculosis Response
(P178517)

Initial Concept-stage
Environmental and Social Risk Screening

A. Introduction

1. The proposed PfR will responds to the Government of Indonesia (GOI) demand and focuses on results – building institutional capacity for improved service delivery and outcomes for Tuberculosis. Similar to the recently approved World Bank operation "National Health Insurance (JKN) Reforms and Results Program" (P172707), the GOI prefers a PfR as the optimal instrument to leverage the GOI's overall reform agenda. The PforR focuses on systematic, behavioral, and institutional changes needed for strengthening Tuberculosis (TB) response. As disbursements are linked to the achievement of priority reform areas, the PfR offers added assurance and accountability that tangible results will be achieved. The GOI will also benefit from complementary capacity building and institutional strengthening activities that will be provided as in-kind technical assistance. The World Bank, with its global knowledge on health systems and service delivery innovations, and its technical expertise in the design and implementation of such reforms, is well positioned to play a catalytic role as a trusted partner and ally to the GOI. Finally, the PfR provides an opportunity to improve coordination among other development partners involved in the sector.

2. In addition, the PfR will leverage additional grant resources from Global Fund using the 'buydown' modality to jointly work with GOI for accelerating the country's TB elimination efforts. In late 2021, Indonesia's Health Minister and CEO of Global Fund have jointly agreed to an innovative, blended finance investment to help align incentives for enhanced subnational performance on TB and addresses other key constraints to achieve better success with TB control in Indonesia. To pursue this agreement, they approached the World Bank to prepare a PfR operation using the 'buydown' modality, following a similar successful example from the World Bank operation in India (India: Program Towards Elimination of Tuberculosis; P167523), approved in 2019.

3. The project will benefit from analytical work and technical assistance being carried out under the Indonesia- Supporting reforms to accelerate UHC or the UHC PASA (P166489) and its successor UHC PASA . These two programs of analytical work have supported the GOI's efforts to accelerate and sustain progress towards UHC by strengthening reforms related to governance, health financing, and service delivery. A special focus of the analytical work was on Tuberculosis, and a number of studies including on non-state actors (link) and an Optima TB Model (link). These analytical programs were co-financed by the Advance UHC Trust Fund, Global Fund for AIDS, TB, and Malaria, and the Gates Foundation.

B. Program Development Objective and Results Indicators

4. The Program Development Objective (PDO) is to improve coverage, quality, and efficiency of TB services in Indonesia.

5. The following preliminary PDO indicators are envisaged to reflect progress towards the different elements of the PDO:
   - Increased TB case detection/treatment rate (coverage, quality)
   - Increased TB treatment success rate (quality, efficiency)
   - Increased proportion of notified TB cases managed at primary care level (efficiency)
   - Decreased delays in treatment initiation OR
   - Loss of follow up of diagnosed cases to treatment – reduce the share of TB cases diagnosed and not put on treatment) (quality, efficiency)
   - Number of private primary care providers that notified TB cases (coverage)
   - A functional, integrated information system linked to mobile health applications is in place (efficiency)

6. These indicators reflect three Results Areas (RAs) that the proposed Bank lending operation is expected to support:
   - **Results Area 1: Strengthened Sub National Tuberculosis Response.** This results area focuses on the establishment of a subnational fiscal transfer mechanisms linked to performance on key indicators important for subnational tuberculosis response. By using incentives within special allocation funds linked to performance (BOK Kinerja), this results area supports MOH to drive performance towards the National Strategic Plan Targets for TB. Particularly important activities that could be measured and incentivized, and which will lead to progress towards the national strategy, and also reinforce the subnational adoption of interventions from other results areas of this Program. Modest and plausible reforms to national health financing methodologies that could fundamentally change the ways in which districts and health facilities are rewarded for reaching their portions of the national strategic goals are:
     1. Improved incentives: incentives for provider can be aligned with the best interest of people who have TB.
     2. Harnessing greater autonomy for primary care providers: Allowing Puskesmas management to use funds where they see the best potential to improve services could generate significant improvements in the quality of service via widespread incremental experimentation.
     3. Improved accountability: investment in a) robust and cost-effective verification methodologies and actors and b) capacity building in public financial management, both necessary prerequisites for the PfR can, over time, materially reduce levels of mis-reporting and other control weaknesses.
     4. Continued equity: Incentivizing providers and district governments for both absolute performance (achieving their proportion of national targets) and comparative performance (improving their results, vs a suitable baseline) can ensure that no facilities or geographies are left without incentives for improvement.
     5. Improving the supporting environment: helping providers to reach the national goals, via better technology and supporting interventions.

     To be effective, such a mechanism will need to be necessarily accompanied by several enablers, some of which can be the potential disbursement-linked results under this results area:
     - Financial autonomy to be able to use the performance incentives
     - Timeliness and predictability of subnational payments

- Sufficient levels of BOK financing and creating adequately funded incentives for the level of effort
- Robust measurement and verification mechanisms for credibility, fairness and objectivity of the system
- Upfront attention to unintended consequences, and to equity considerations, in the design

Moreover, since there is a parallel source of significant funding from JKN, which is similarly expected to be increasingly linked to performance, there is a clear and stated need for alignment of structures and incentives between JKN and BOK.

Factors which affect levels of demand for services at Puskesmas (e.g., a) Puskesmas opening hours, b) tendencies or policies that always refer any co-morbidities to secondary care and c) the lack of incentives to refer back to primary care once an individual is a secondary facility) will also be a critical success factor. Without considering them, Puskesmas will not absorb an optimal proportion of the overall burden of TB care.

- **Results Area 2: Strengthened TB care among private health providers.** Currently, there are several limitations in effectively engaging the private sector in providing services to TB patients, especially at the primary care level. The overall hospital centricity for uncomplicated TB is also a cause for concern. Currently, there are two ongoing initiatives that closely complement this results area, through the Global Fund (District level public private mix or PPM approach) and USAID (TB Private Sector- TBPS) activities. The District PPM Approach relies on subnational health staff at districts and Puskesmas levels to engage with private providers, with the help of local members of the many professional medical associations. Capacity, bandwidth and motivation of the health staff to undertake this role, clarity on guidelines and payment modalities involved, and improving linkages with the diagnostics and treatment supplies under the national TB program are potential areas for further strengthening. The country's national health insurance program, JKN, also offers opportunities for strengthening TB response through the contracted private primary care providers. Improving this engagement has considerable potential to improve case detection rates for Indonesia, while also improving the ease of access and financial protection for patients who seek care at such private providers. Improving JKN incentives for care of uncomplicated TB~~,~~ and enhancing the interoperability of JKN information systems with those of the TB program, together offer opportunities for further harmonization and added impact for the national TB program. Interventions through the Program will support and strengthen the ongoing initiatives as well as identify innovative approaches that help improve the engagement of private providers in primary care settings, facilitating access to their patients for the services available under the national TB program. This results area will also consider initiatives that may help improve the attention of hospitals to refer back uncomplicated TB patients for care at the primary care level, as well as to better track treatment completion for services directly administered by them.

- **Results Area 3: Enhanced digital systems for Tuberculosis.** Results area 3 aims to create a digital ecosystem for the TB program, aimed at minimizing the reporting burden while improving data availability to inform better equity, access and monitoring of the program. The ecosystem would use the patient's health record as a single point of integration that makes it possible to better track the patient journey, provide support to service delivery, minimize reporting burden, enable monitoring and verification systems, and also help with financial allocations and claim payments. This digital ecosystem would consolidate data from a wide range of legacy applications and should ameliorate under-reporting of TB cases, which has been a persistent issue over recent years, and is particularly the case for reporting by large hospitals. Building on the country's COVID-19

information system and its achievements, the MOH's vision is to build a system that can use QR codes for data entry and inputs, and capture all transactions digitally, so that reporting is delivered automatically, does not impose any additional burden and is not dependent upon the availability of a stretched health worker to enter data manually (currently this is frequently the cause of delayed reporting). This would pave the way for similar digital ecosystem enhancements across all primary care programs.

C. Program Boundary

7. The program boundary is defined along the following dimensions:
   - Program focus: The Program will focus on strengthening the GOI's national tuberculosis response by i) strengthening subnational TB response, ii) strengthening the engagement of private health providers; iii) enhancing digital systems in TB. The national TB program has ambitious targets to reduce incidence of new TB cases by 50 percent by 2025, and by 90 percent in 2030. To achieve these ambitious targets, the strategy is to increase case findings with outreach activities, undertake contact tracing of close contacts and increased screening, and controlling identified risk factors. The national TB strategy for 2020 – 2024 also includes improved quality of TB case management to increase retention and compliance in treatment, strengthened engagement with private health providers and with the national social health insurance agency (*Badan Pengelola Jaminan Sosial Kesehatan* or BPJS-K), as well as improved linkages between diagnostic, notification, and treatment services. The use of digital technologies and simplification of the existing information system for TB will be a critical element to support the efforts to achieve the ambitious targets.
   - Ministry with core responsibilities: Although the implementation of the national agenda to eliminate TB (the government program) will require a multi-sectoral approach, by involving other ministries and government agencies, the Program sets the boundary for activities within the purview of Ministry of Health. The implementing agency for the Program is MOH, and the main unit responsible will be the Directorate of Communicable Disease Control, within which the National Tuberculosis Program is housed. The Bureau of Planning under the Secretary General of MOH, and the newly established Board for Health Policy (BKPK), especially one of its centers, the Center for Health Financing and Decentralization (Pusjak PDK) will play a key role in the design of the performance-based BOK. The Directorate for Pharmaceuticals has a significant roles in the procurement of TB program drugs and commodities, especially for diagnostics, such as cartridges for the rapid molecular machines. Other units that are involved in the national TB program include the Directorate General of Health Services, especially those responsible for health facility readiness and quality of service at the primary and secondary level of care.

D. Geographic Scope

8. The program is to be implemented nationwide**.**

E. Initial E&S Risk Screening

9. An initial concept-stage environmental and social (E&S) risk screening was systematically carried out by the ESSA team for all proposed Program activities across four risk criteria: (a) Likely E&S effects, (b) Contextual risk factor, (c) Institutional capacity and complexity risks, and (d) political and reputational risks. The overall environmental and social risk is classified as **Moderate**, with environmental risk rated Moderate and social risk rated Moderate.
10. Environmental risks are related to suboptimal management of medical solid waste and wastewater generated from as well as TB contamination to healthcare workers during provisions of TB treatment and care. While most of activities will take place in existing Puskesmas and General Practitioners clinics

with the procedures and facilities to handle such waste are in place – the increasing volume of waste and lack of proper implementation and supervision may increase the potential pollution risk to the environment as well as OHS risks to the healthcare workers. Mitigation of these environmental risks will be sought through standard procedures as required by GoI laws and regulations on infection prevention control measures, occupational health and safety, and medical waste management.

11. The social risk for the Program is considered **Moderate.** The overall social outcome is expected to be positive. The Program is expected to increase case findings with outreach activities, undertake contact tracing of close contacts and increase screening, and controlling identified risk factors. In the longer-run, the Program also will reduce TB incidence, disease burdens, mortality and socio-economic cost. The program is expected to result in the number of individuals with TB that need close monitoring to finish their TB treatment. Active contact tracing without proper procedure from providers (attitude, etc.) could lead to social issues to TB patients, particularly social stigma, which may increase risk of non-compliance for individual suspected of TB and TB patients. Work safety procedures, interpersonal communication skills, psychosocial education training and respectful working environment for the healthcare providers and individuals suspected of TB is required to be included in the Program. The Program will improve data availability, access and monitoring of TB program by using the patient's health record. While the Program will advance digitization for TB, there is risk on data security and individual consent for data sharing between public and private institutions, government and care providers. The program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities. There are no anticipated adverse impacts on Indigenous Peoples, and/or assets or people livelihoods. The Program will unlikely involve issues on social exclusion or vulnerable peoples being excluded to receive Program benefits since most TB patients are included poor communities/vulnerable groups. However, the Program will need to include specific strategies to ensure equitable access for vulnerable population including people from lower income group, individuals with disabilities, and ethnic minorities or Indigenous Peoples.

12. Assessment on relevant GoI regulations and institutional systems, including capacity of IAs to apply GoI requirements will be performed through the Environmental and Social Systems Assessment (ESSA) process prior to the Program's appraisal.

13. Table A presents the initial risk screening:

Table A. Initial E&S Risk Matrix

PDO: To improve coverage, quality, and efficiency of TB services in Indonesia.			
Expenditures: The program's expenditure framework will include the budget under the National TB Program and BOK transfer to districts and *Puskesmas*. A detailed analysis of these two expenditure categories will be done during project preparation.			
Result Areas	**Program Activities**	**Environmental Risks**	**Social Risks**
RA1: Strengthened Sub National TB Response	BOK (health operational grant) transfers to *Puskesmas* and Districts based on TB performance in public and private sectors	**Likely Environmental Effects: *Moderate*** The overall environmental outcome of the proposed PfR is expected to be positive. The PfR is expected to strengthen health service system response to TB which will improve	**Likely Social Effects: Moderate** The PfR is expected to provide incentives for providers and district government so that equity is ensured where no facilities or geographies are left without incentives for improvement. This program will mostly benefit the broader population

		community/public health safety by containing TB transmission to the broader population. The Program will also ramp-up the capacity of healthcare workers/staff to ensure provisions of proper treatment and care while at the same time will also reduce OHS risks from TB contamination to healthcare workers during case handling. There is no physical construction or major civil work envisage as part of the Program. However, there is a moderate likelihood that the proposed Program activities would lead to some environmental risks including environmental pollution due to suboptimal management of medical solid waste and wastewater, Occupational Health and Safety (OHS) for medical workers, and community health and safety related to handling, transport and disposal of medical waste. The information systems improvement and integration will be done utilizing the currently available ICT equipment thus e-waste generation is not anticipated. During implementation of Indonesia Emergency Response to COVID19 Program (P173843), the IA shown improved capacity in managing communicable disease cases as well as medical waste handling. However, limited needs for capacity-building measures will be required to ensure these risks are properly managed and mitigated. **Contextual risk factor: *Low*** The environmental setting of the Program does not pose any contextual challenges that require unproven mitigation or management measures. The	and affected individuals from the early diagnosis and treatment. The Program will increase the number of people screened, diagnosed with and treated for TB by also creating access for diagnostics and drugs provided by the GoI for privately notified patients. Subsequently, the program will increase the number of suspected TB cases, and patients that need to be monitored closely to ensure full compliance for TB treatment. There is a moderate likelihood concerning work safety procedures and respectful working environment for the healthcare providers and individuals suspected for Tb. There is a moderate likelihood that people diagnosed and treated with Tb as well as health care providers will face social stigma, that will affect compliance level for diagnosis and to finish TB treatment. While the Program will advance digitization for Tb, there is a moderate risk on data security and individual consent for data sharing between public and private institutions, government and care providers. There is moderate risk for equitable access for TB diagnosis and treatment for people in the vulnerable population, including people in the lower income level, people in the marginalized population, people with disabilities. Affected individuals, especially from lower income level have higher risk or facing catastrophic costs from losing jobs and income, having to bear the indirect medical cost, including food supplement, transportation cost and work absenteeism during the treatment period. These might result in inequitable access to care, to receive timely treatment and to finish TB treatment.

		Program's activities are not going to be implemented in or near sensitive habitats, nor will they have any direct cumulative effect on the environment. **Institutional capacity and complexity risks: *Moderate*** The Program implementation will involve several Directorates within the Ministry of Health, while at the same time will involve numerous *Puskesmas* and GPs at District level. These may impede IA's ability to effectively carry out its environmental risk management roles and responsibilities. Additionally, even though during implementation of Indonesia Emergency Response to COVID19 Program (P173843) the IA shown improved capacity in managing communicable disease cases, there is a record of poor TB service quality assurance framework and oversight which may increase the OHS risk to the health care workers. IA's capacity in managing e-waste is not yet known. Such capacity constraints can potentially increase the level of potential environmental risks associated with the operation. Further assessment of the existing GOI's instruments, systems, resources and capacity (both at the national and subnational levels) will be made through the ESSA process prior to the Program's appraisal. **Political and reputational risks: *Low*** The Program will not pose any special challenges or threats to the environmental settings. **<u>Overall assessment:</u>**	The program will also benefit children with higher risk of infection by containing TB transmission in a household and preventing complication later on in their lifetime. However, there is a moderate likelihood that children who must receive TB treatment will face school absenteeism. Moreover, there is a moderate likelihood that children with household members diagnosed with TB might also be impacted by social stigma, that will further might increase noncompliance, if families are not well informed and stigma not addressed properly. The Program must include work safety procedures, interpersonal communication skills, psychosocial education training and respectful working environment for the healthcare providers, individuals suspected of TB, and individual and family with TB cases. There is a moderate likelihood that vulnerable peoples will face barriers to access quality TB services. Those include people live in remote areas including Indigenous Peoples and disability groups. Although the Program will mostly address and target people in the poor income group, however limited services available in remote areas and people with disabilities have additional barrier that affect to access health care services. The Program needs to include specific strategies to ensure equitable access for vulnerable peoples. **Contextual risk factor: *Low*** The social setting of the Program does not pose any contextual challenges that require unproven mitigation or management measures. **Institutional capacity and complexity risks: *Moderate*** The Program implementation will involve several Directorates within the Ministry of Health, while at the same time it will involve numerous

		The environmental risk for the Program is considered **Moderate.** The Program is not expected to have significant adverse and long-term direct environmental impacts. The Program will likely result environmental pollution due to suboptimal management of medical solid waste and wastewater, and pose community OHS risks for medical workers in providing medical care for TB patients as well as community health and safety risks related to handling, transport, and disposal of medical waste. The Program is also likely to generate limited amount of e-waste at the end of life of the ICT equipment from the technology upgrade activities. The operation may have some adverse E&S impacts, but they would tend not to be in environmentally or socially sensitive areas. The operation is unlikely to have significant adverse impacts on GHG and would not be at risk of natural disasters (flooding, earthquake, or severe weather events). Even though the Program will be implemented nationwide, these risks are well understood and manageable with standard procedures and will not require unproven mitigation or management measures. Additionally, it is highly likely that the Program achieves its operational objectives and sustain the desired environmental outcomes due to low to moderate contextual, institutional	*Puskesmas,* private institutions and GPs at District level. The social risk from the Program will require a multi-sectoral approach, by involving other ministries and government agencies, beyond the Ministry of Health. For example, the risk of TB patients losing jobs may need policy interventions from the Ministry of Labor. The risk of facing catastrophic spending can also be addressed with social protection or financial support for people in the lower economic level, that are beyond the authority of Ministry of Health. These capacity constraints can potentially increase the level of social risk with the operation. **Political and reputational risks: *Low*** The Program will not pose any special challenges or threats to the social settings. **Overall assessment:** The social risk for the Program is considered **Moderate.** The overall social outcome is expected to be positive. The Program is expected to increase case findings with outreach activities, undertake contact tracing of close contacts and increase screening, and controlling identified risk factors. In the longer-run, the Program also will reduce TB incidence, disease burdens, mortality and socio-economic cost. However, active contact tracing without proper procedure from providers (attitude, etc.) could lead social issues to TB patient, including social stigma. Work safety procedures and respectful working environment for the healthcare providers and individuals suspected of TB is required to be included in the Program. The Program will improve data availability, access and monitoring of TB program by using the patient's health record. While the Program will advance digitization for Tb, there is risk on data security and individual

		complexity/capacity, or political and reputational risks.	consent for data sharing between public and private institutions, government and care providers. The program is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities. There are no anticipated adverse impacts on indigenous peoples, and/or assets or people livelihoods. The Program will unlikely involve issues on social exclusion or vulnerable peoples being excluded to receive Program benefits since most TB patients are included poor communities/vulnerable groups.

ANNEX 2. Alignment of PforR Program with GOI program for TB Strengthening Response

The National TB Program

Key health priorities from RPJMN

- Maternal and child health, including nutrition
- Communicable diseases (**TB**, HIV)
- Non-Communicable Diseases (diabetes mellitus, hypertension, cardiovascular disease, asthma, chronic obstructive pulmonary disease, stroke, lupus erythematosus syndrome, epilepsy, chronic mental health problems)

TB priorities based on the TB National Strategy 2020-2024	**Supported by PforR**	
Strengthening commitment and leadership of central, provincial, and district/municipality government to support the acceleration towards tuberculosis elimination 2030.	RA1, RA2	√
Increasing access to high-quality and patient-centered tuberculosis diagnosis and treatment services	RA3, RA4	√
Optimization of promotion and prevention efforts, provision of tuberculosis prevention therapy and infection control		X
Utilization of research findings and technologies for screening, diagnosis, and management of Tuberculosis	RA7	√
Increasing communities, partners, and multi sectoral (including private sector) participation in TB elimination	RA3, RA4, RA5	√
Strengthening program management through health system strengthening	RA6	√
Cross-cutting		
Improving system governance and accountability	RA1, RA6	√
Accelerating the integration of information systems	RA6	√
Strengthening purchasing arrangements (capitation, KBK, INACBGs)	RA5	√

Total GOI program: US$ 1.300 billion (3 years)
The GOI program supported by the PforR (estimated US$724 million)

ANNEX 3. CORE PRINCIPLES AND PLANNING ELEMENTS

This matrix is in line with the Interim Guidance Notes to Staff on Assessments (July 18, 2012 version). It is intended to guide assessment of existing borrower program system to plan and implement effective measures for Environmental and social risk management. They serve as a basis for provision of Bank implementation support.

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
Core principle 1: Program E&S management systems are designed to (a) promote E&S sustainability in the Program design; (b) avoid, minimize, or mitigate adverse impacts; and (c) promote informed decision-making relating to a Program's E&S effects.				
1	The PforR system operate within an adequate legal and regulatory framework to guide E&S impact assessments, mitigation, management and monitoring at the PforR Program level.	Relevant	Relevant laws and regulations are available; for instance environmental impact assessment (AMDAL), occupational health and safety, public health and safety, and waste management.	Ministerial regulation regarding type of business plan and/or activities under public works that require environmental management efforts and monitoring efforts (UKL-UPL) gives provision on thresholds for activities that do not require UKL-UPL.
2	The PforR system incorporate recognized elements of good practice in E&S assessment and management including: i. Early screening of potential impacts. ii. Consideration of strategic, technical, and site alternatives (including the "no action" alternative). iii. Explicit assessment of potential induced, cumulative, and transboundary impacts. iv. Identification of measures to mitigate adverse E&S risks and impacts that cannot	Relevant	National environmental regulatory system (AMDAL) includes these elements (i) to (v)	

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	be otherwise avoided or minimized. v. Clear articulation of institutional responsibilities and resources to support implementation of plans vi. Responsiveness and accountability through stakeholder consultation, timely dissemination of the PforR information, and responsive GRMs.			
Core principle 2: Program E&S management systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program. Program activities that involve the significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR financing.				
1.	The PforR Program system identify, and screen for adverse effects on potentially important biodiversity and cultural resource areas and provide adequate measures to avoid, minimize, or mitigate adverse effects.	Not relevant	Not relevant	Not relevant
2.	The PforR Program system support and promote the protection, conservation, maintenance, and rehabilitation of natural habitats.	Not relevant	Not relevant	Not relevant
3.	The PforR Program system avoid significant conversion or degradation of critical natural habitats. If avoiding the significant conversion of natural habitats is not technically feasible, include measures to mitigate or offset the adverse impacts of the PforR Program activities and take into account potential adverse effects on physical cultural property and provide adequate measures to avoid,	Not relevant	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	minimize, or mitigate such effects.			
Core principle 3: Program E&S management systems are designed to protect public and worker safety against the potential risks associated with (a) the construction and/or operation of facilities or other operational practices under the Program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials under the Program; and (c) reconstruction or rehabilitation.				
1.	The PforR Program system promote adequate community, individual, and worker health, safety, and security through the safe design, construction, operation, and maintenance of Program activities; or, in carrying out activities that may be dependent on existing infrastructure, incorporate safety measures, inspections, or remedial works as appropriate.	Relevant		
2.	The PforR Program system promote the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated under the PforR.	Relevant	National environmental laws and regulations that governs the following: ▪ Law No. 32/2009 on The Protection and Environmental Management, requires management of materials and wastes that are classified as dangerous and/or poisonous or B3 (*Bahan Berbahaya dan Beracun*) ▪ Government Regulation No. 74/2001 on Management of Hazardous Materials), Government Regulation No. 101/2014 on Management of Toxic and Hazardous Waste	
3.	The PforR Program system promote the use of integrated pest management practices to	Not relevant	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	manage or reduce the adverse impacts of pests or disease vectors			
4.	The PforR Program system provide training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous chemicals in accordance with the relevant international guidelines and conventions	Relevant		
5.	The PforR Program system include adequate measures to avoid, minimize, or mitigate community, individual, and worker risks when the PforR Program activities are located in areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or affected by climate events.	Not relevant	Not relevant	Not relevant
Core Principle 4: Program E&S systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement and assists affected people in improving, or at the minimum restoring, their livelihoods and living standards				
1.	The PforR Program system avoid or minimize land acquisition and related adverse impacts.	Not relevant as the PfR is not envisaged to finance infrastructure construction that requires land acquisition	Not relevant	Not relevant
2.	The PforR Program system identify and address economic or social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to resources they use or occupy.	Not relevant as above	Not relevant	Not relevant
3.	The PforR Program system provide compensation sufficient to purchase	Not relevant as above	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	replacement assets of equivalent value and to meet any necessary transitional expenses, paid before taking land or restricting access.			
4.	The PforR Program system provide supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment).	Not relevant as above	Not relevant	Not relevant
5.	The PforR Program system restore or replace public infrastructure and community services that may be adversely affected by the Program; include measures in order for land acquisition and related activities to be planned and implemented with appropriate disclosure of information, consultation, and informed participation of those affected.	Not relevant as above	Not relevant	Not relevant
Core principle 5: Program E&S systems give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and to the needs or concerns of vulnerable groups				
1.	The PforR Program system undertake meaningful consultations if the Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities are potentially affected (positively or negatively), to determine whether there is broad community support for the PforR Program activities.	Not relevant	Not relevant	Not relevant
2.	The PforR Program system ensure that Indigenous Peoples/Sub Saharan African	Not relevant	Not relevant	Not relevant

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
	Historically Underserved Traditional Local Communities can participate in devising opportunities to benefit from exploitation of customary resources and indigenous knowledge, the latter (indigenous knowledge) to include the consent of Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities.			
3.	The PforR Program system give attention to groups vulnerable to hardship or discrimination, including, as relevant, the poor, the disabled, women and children, the elderly, ethnic minorities or other marginalized groups; and if necessary, take special measures to promote equitable access to PforR Program benefits.	Relevant	Law No. 8/1999 on Consumer Protection, all citizens have the rights to choose health services, to be treated without discrimination, to have access to information regarding services, to be heard, to be treated with fairness and have legal access to litigation. The law also protected access to health services for people with disabilities. The Presidential Regulation No 67/2021 calls national and sub-national government to ensure that Tb patients and family members to have access to health and social protection, to non-discriminatory services. The National Strategy for TB Control includes specific strategies to reach high-risk and vulnerable population in TB. Decree of the Minister of Health No. 1278 / Menkes / SK / XII / 2009 on guidelines for implementing collaborative control of TB and HIV diseases calls for collaboration mechanism between TB and HIV/AIDS health services to increase access in that high-	The national TB program that has not include specific strategy to target marginal and vulnerable population may increase concerns on equitable access. The national TB program defines vulnerable population as those with the higher risk for TB infection, not necessarily to those with limited access to healthcare services. Guidelines for the unreached population target those with HIV and living in prison as well as congregate settings. As a result, the national TB strategies including communication strategy does not include other vulnerable peoples, including people with disabilities or indigenous population.

No	Key Attributes related to Core Principles	Relevance to Program	Provisions in System	Practice
			risk population. Rights for people with disability are protected under Law No. 8/2016 that include, among other things, rights to be free from stigma, for health, education, jobs, privacy, accessibility, and public services.	
Core principle 6: Program E&S systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes				
1	The PforR Program system consider conflict risks, including distributional equity and cultural sensitivities.	Not relevant	Not relevant	Not relevant

ANNEX 4. STAKEHOLDER CONSULTATION

Date	15 June 2022
Respondent	Henry Diatmo, Thea Hutanamon
Institution	Stop TB Partnership Indonesia
Topics	**Meeting Notes**
General Profile	- Stop TB Partnership Indonesia (STPI) is a CSO focusing on TB elimination towards partnership with government, private sectors and CSOs. STPI is part of the Konsorsium Penabulu-STPI that manage GF grant for TB Community Program 2021-2023 from the Global Fund.
Key Issues	- At the moment the approach use for IPC is TemPo in health facilities. But there is very limited efforts in community for infection prevention control. One of the concern is that there is no guideline for IPC at home. Cadres communicate to patient without IEP about IPC in the community level. There is also no TB IPC guideline in school settings. - MOH have health promotion material on coughing ethics. Before pandemic there is no awareness on wearing masks. There is shifting norm on wearing mask after the pandemic. - There is category for healthy house with ventilation launched by MOH. But there is enforcement and not included in the permit to build house or buildings. - There are NGO working on house renovations for TB patients. - There is no specific guideline for TB IPC for household member. IPC training is available for healthcare workers. Cadre also does not have certified training materials from MOH. - There are training for healthcare workers regarding TB DOTS, wasor and advance. The training include education for patients at home. There are communication and information forms developed by the PR community which include information from MOH. - MOH launched guideline for TB prevention on Pesantren, TNI POLRI, schools, and prisons. The dissemination is limited, mostly limited in the government or among TB activist. The guideline is hard to be accessed, it's somewhere places in the NTP website. There is also guideline for TB treatment for JKN patients in 2012 which not widely shared. There is no monitoring on the implementation for these guidelines. MOH never survey on the enforcements of the implementation. The information in MOH is also scattered. - There is no specific communication strategy to prevent or reduce stigma. PR Community is working on TB stigma assessment. Result from the TB stigma assessment will be discussed with government and stakeholders for further recommendation. Based on Perpres 67/2021 Minister of Law and Defense is the one that will be responsible to handle issue on stigma. MOH planned to create module on TB stigma, human rights and gender using national budget but the process is still uncertain. There is possibility that the module will be developed with support from GF. In the national strategy plan launched by NTP MOH include plan to develop communication materials regarding stigma. - In the beginning of PR community training for cadres in community were developed by the PR itself and trained to SR, SSR and cadres in 20 districts. In STPI Grants with CFCS there was module launched by APCASO. But there was no monitoring for the implementation.

	- Stigma toward health care provider that treat TB is not a problem. But there is a problem about stigma toward TB patients from health care providers. There is a national survey on human rights violence toward TB patients, including issue on patients' data security. There is issue of distrust from patients to healthcare providers and cadres that treat TB that they might leak the patients' data. There is report on violence abuse in the household due to TB patients. 9% patients reporting stigma. - Community led monitoring, initiated by STOP TB global. PR community plan to do reporting for patients with stigma. There was application about oneImpact adopted by STOP TB global to do reporting. POP TB is planning to launch call centre for Tb patients or to ask about TB. There was no call centre or channel for FGRM for TB patients operated by MOH. There is no channel for FGRM. - There are training for legal support for TB patients developed by PR community for SR and SSR. Reporting including to Irjen Kemkes, Lapor.co.id, ombudsman, to human rights committee. Unsure about the use of the reporting system, there was no monitoring system. - There is no specific approach or strategy to target vulnerable population except for HIV patients because it was part of GF indicator. In global there was specific approach and strategy for each vulnerable population. - There are no guarantee for patients's data protection by the cadres when doing case finding. If the cadres or health care providers are known by the community that when they visit houses meaning that there are TB patients in that house. There is no SOP for sharing SITK data to MOH, PR community can share patients' data with MOH with no specific SOP that ensure data protection. The process was simplified with NDA signed by the SR and SSR. - Stigma and discrimination become the main challenges in sharing data to protect patients' privacy. There should be regulation regarding patients data protection for cadres, and clarification on who can use the data. There should also be protection to support the work for doing Tb surveillance. - The concerns of using peduliLindungi for TBC is due to some discrimination. For example in freeport, having TBC is part of the eliminating and minus points to get accepted working in the company. - There is no legal protection to prevent company to not accept patients with TBC. Although it is illegal to terminate worker with TBC, but there are cases in where workers are encouraged to quit. YKI used to have grants about TB in workplace to informed HRD and professional association about TBC and to do screening in TBC until the workers are treated. There are needs to inform the management to prevent discrimination for TB workers, including how many weeks do they need to take leave before going back to the office.

Date	21 June 2022
Respondent	Heny Akhmad, Barry Adhitya, Sugeng, Aris, Budi Hermawan, Fitria
Institution	Konsorsium Penabulu-STPI; POP TB
Topics	**Meeting Notes**
General Profile	- Konsorsium Penabulu-STPI is the Primary Recipient for Global Fund TB Community Program 2021 to 2023. It currently working closely with the MOH, PHO, DHO, Puskesmas, and community cadres in implementing TB Community Program in 30

	Provinces and 190 Districts. PR Konsorsium also works on advocacy, cadres training, and research on TB stigma. - POP TB is a TB patients organization that also a Thematic Secondary Recipient for Global Fund TB Community Program 2021 to 2023. POP TB is currently working in 180 districts, and have branches in 23 areas, including eastern part of Indonesia.
Key Issues	- PPE for community workers are limited, the budget available is limited so the volume is limited. The PPE is already standardized. Many health facilities are limited in providing room and facilities for TB patients - From TB stigma assessment in 8 Provinces, Konsorsium found that 40% of TB patients suffer from self stigma. Some are patients with higher risk for stigma like TB survivor LGBT community. The highest stigma are from neighbor and second from health workers. Stigma on TB are high on MDR TB patients although there are issues that patients with Drugs Sensitive TB still face stigma. Campaign on stigma and discrimination found that the awareness about TB are lacking, and that are no training or information about how to prevent stigma. - Discrimination on workplace include job security, there are cases where TB patients are laid off from their workplace. Patients need policy to provide protection to ensure job safety. Patients suffer from stigma from health care providers. Many health workers and cadres work closely with TB communities suffer from discrimination and TB stigma. Patient with MDR TB suffer from discrimination at work and risk for losing job. Patients usually report complaints on discrimination to cadres or communities. POP Tb try to provide hotline or FGRM system for discrimination. POP TB try to develop channel for patients to report using google form. There are no reporting channel to MOH for TB patients. There are guideline from MOH for communication, but the communication strategy are not yet cover the high risk population nor it is targeted to vulnerable population. - There are Directorate General for Health Services Decree 2021 on Infection Prevention Control (IPC), but community workers or volunteers are yet to be included. Cadres are responsible for contact tracing and monitoring treatments. There are no regulation to protect community workers and volunteer that works with TB patients. Things need to be done to protect community that works closely with TB patients, including how to ensure IPC and safety protocol. IPC include routine activities during contact tracing, sputum transport. There is not yet protocols and manuals to ensure implementation of IPC for cadres. - There are IPC for health workers that work for MDR TB patients, but there is a need for clear guideline for the use of PPE for community workers. Including procedures during visitations in patients houses or when do TB tracing. There are no PPE guideline for community workers. There are guideline from MOH for contact tracing and to assist MDR TB patients. Currently 2 masks are needed each month and mask can be used for five days by these community workers. Guideline for MDR TB mentions to do screening for community workers at least once a year but there are no implementation yet. PR Community are responsible to provide PPE for the 9000 cadres that under their projects. There are no report of different treatment between community cadres or Puskesmas's cadres . - Patients data security are limited to cadres commitment form about patients data security. For community workers data patient safety are part of the work agreement. There are needs for health workers to inform patients about data

	privacy and the need for data sharing for tracing purposes. Patients are usually more acceptance for data sharing when they understand the benefit and that their data are not used for commercialization. There are unclear guidance how far is data security must be kept and can be or can't be shared to ensure patients safety. There should be no redundancy in collecting patients data. - There are big challenges for health community workers that closely work with TB patients. Even there are not some protection but it still sub-standard. There are not yet insurance or work protection for people that work for TB patients. Protection for community workers safety are very important to ensure program delivery. - From BPJS there are regulation that only cover half of the TB patients, and they need to pay that half when they are referred to hospital by GP clinic. They can only access free drugs in Puskesmas. Clinics usually do not aware where patients can access free TB drugs for patients. There are some cases where patients are not informed how to access TB drugs.

Date	23 June 2022
Respondent	Dr. dr. Erlina Burhan, MSc., Sp.P(K); dr. Herikurniawan, SpPD, KP; Dr. dr. Fathiyah Isbaniah, SpP(K), MPd.Ked; dr. Anna Uyainah, SpPD, KP, MARS; dr. Nastiti Kaswandani, Sp.A(K); dr. Lia Kusumawati, MBiomed, Ph.D, SpMK(K); Sri Poerwaningsih, SKM, M.Kes; dr. Imran; Dr. Iwan Rivai Alam Siahaan, Sp.Ok; Dr. dr. Istillmiati Fujiati, MSc, CM-FM, MPd. Ked; apt. Lilik Yusuf Indrajaya, SE., S.Si., MBA; Dr. Astuti Yuni Nursasi, S.Kp, M.N.
Institution	KOPI TB
Topics	**Meeting Notes**
General Profile	KOPI TB is a Medical Professional Association for Tuberculosis in Indonesia that consists of fifteen associations including general practitioner, medical specialties, nurses, pharmacists, and midwives. KOPI TB was established as advocacy and coordination platform on TB among medical professionals in national and sub-national level.
Key Issues	- Puskesmas and primary clinics need sufficient resources to ensure the implementation of high quality Tb services delivery from tracing, screening, diagnostics, to treatment. Quality of services need to be increased as problems of LTFU and MDR TB all started with the poor quality of services. To ensure quality, there is need for incentive which could be in the form of CME or privileges in providing BPJS. The existence of trained and dedicated personnel that focus on TB in Puskesmas are considered lacking. Currently, not all private health facilities or labs have SITB. Private lab are not all informed and trained in sample packaging for TB while it is the same packaging for covid-19. While Puskesmas should be able to treat Tb patients with uncomplicated comorbid diseases, many providers prefer to refer the patients due to limited facilities and understanding. There are needs to increase capacity for the HR to treat TB patients with comorbid diseases. A virtual medical group with which primary clinic can consult with the health care provider in hospitals might reduce referral while ensuring quality of care. Healthcare providers should incentives with accreditation points as part of their CME. Availability of TB Prevention Treatment are still an issue in many places and need better monitoring system. Currently, midwives are not equipped with screening instrument. Current screening tool use a questionnaire that are not convincing enough for patients to be referred. There is a need for testing tools that are widely available and easy to use like swab test for Covid-19 to increase diagnostic.

	- As many TB patients prefer to go to private health facilities, partnership between government and private sectors should be simplified so the system can be linked, standardize and uniform. There are resistance from patients to go to government health facilities and prefer to go to private health sectors. Solution for this matter is to include all private health care providers to the DPPM networks and to make it as part of requirements for private health facilities to have SITB. Private facilities need to be informed with the guideline to diagnose TB, how to access fast molecular testing in government facilities, how to send sample using Postal office, and how to do safe packaging for the sample. Private healthcare facilities are facing limited access to treat TB patients, to have facilities that comply with infection prevention control (IPC) protocols. Contact tracing are also limited to Puskesmas that has cadres. Moreover, there are concerns that cadres are not health workers and has no capacity or trainings to do the contact investigation safely. There are need to ensure protection for cadres or health providers, which include social and health protection. Learning from Covid-19, the reporting system which use NAR have provide a strong network for real time reporting which potentially be used in TB. Government should use current network established during Covid-19 response to increase the number of reporting and diagnostics in private health facilities. - Some guidelines for TB diagnostics are difficult to be implemented, and primary care clinics are not allowed to provide x-ray testing. Current guideline mandate patients with Diabetes or comorbid diseases to have periodic x-ray every three months. However, the implementation will increase number of referral from primary care health facilities to hospitals for diagnostics which are not allowed by the BPJS-K system. The flow for diagnostic that rely heavily on sputum checking should be pivot into x-ray which is easily done but the challenges to have x-ray in primary health services remain as currently primary care clinics cannot have permit to have x-ray. - Making diagnostic tools widely available and accessible will reduce number of referral. MoH set target in 2022 that 133 health facilities should have and be able to provide GeneExpert or fast molecular testing. There is need for more sensitive cartridge to be widely available. In 2022, there should also be 38 labs that are certified for TB culture testing. However currently there are only 22 labs that are certified for culture testing and 15 labs that can do drugs susceptibility testing (DST) for MDR-TB. TB diagnostics require the use of fast molecular testing, unless sputum are not available than health providers can use clinical diagnostics using chest X-ray. There should be more research and innovation in making Tb diagnostics with high validity more widely available. - For having TB molecular testing in referral labs, health care providers can send patients' sputum using postal office services. Sending sputum sample are possible nationwide from government hospitals, which are facilitated by the district health official. Postal office will send report to health care providers in the labs to ensure the temperature and SOP are well monitored. Almost every day, DST labs receive samples that are referred from other Provinces using postal office service. - TB active case findings and treatment need to be more accessible. There are not enough nor system to monitor the implementation of active case findings in high risk groups outside health facilities, like in school, people with comorbid for TB or in elderly population. Many general practitioner and specialist doctors still refer TB patients to pulmonologist. While KOPI TS in working on guideline so that all

	specialists can provide TB treatment, the implementation will need to incentivize the healthcare providers. Patients should have access for TB treatment delivers services, in which they can have digital consultation during their treatment period with clear guideline which selected patients need to have in person visit. - The use of digital technology to support TB service delivery is crucial, yet the implementation must consider the limitation of internet connection in rural areas. The use of Artificial Intelligence in radiology are considered to be useful as number of radiology specialist are limited, especially in more remote areas. Telemedicine should be utilized to increase access for treatment monitoring and drugs delivery. Real time reporting from nation-wide hospitals and laboratories during covid-19 has proven that the use of digital technology to fasten the process is possible. Learning from Covid-19 reporting should be a benchmark for TB reporting, in which real time reporting and the use of the report by multi stakeholders is feasible. - Health care providers need to be trained and equipped with not only knowledge on medical aspect but also on the communication skills, to prevent and to reduce TB stigma. Many patients are refusing treatment because of stigma. Cadre and health care providers should have communication training and equipped to ensure that patients are informed and convinced to prevent delay treatment or Loss To Follow Up. Health facilities should have dedicated unit to provide information for TB patients and provide non-medical supports for TB patients, like support for nutrition. Cadres who assist TB patient should have channel to consult problems that are faced by patients, like issues on drugs side effects, nutrition needs, etc. KOPI Tb are working on coaching for health workers so they have competencies to do coaching for family and TB patients. Family should also provide support, and health care providers should be able to give coaching to family members. Some families need more than information but need more efforts to be educated and convinced that TB can be cured and that all families should be diagnosed and treated. Involvement of local authorities like from RT/RW will help in convincing families and to mobilize communities to get tested and to ensure treatment. Digital channel to consult online might provide better access and trust from patients. - Education and non-medical treatment to ensure patients compliance are needed. Education is important and play important roles. TB patients need to be maintained for the whole six months during period of treatment. Currently, doctors and nurses in TB clinics are providing education for patients. There should be dedicated platform for patients to access information about TB, like #141cekTBC campaign, and to do digital consultation in which they might feel more secure regarding their privacy. Patients are that notified in the digital system as TB patients should be automatically links to this access for information. Social supports should be available and accessible for patients in the early treatment phase in where they need to be isolated. There is need for isolation facilities for TB patients, who lived in crowded household, in the beginning of their treatment. However, the isolation place should be named or designed that it will not increase resistance and stigma. - Communication strategy, training and implementations is important to ensure public health safety, to increase patients' compliance and to reduce stigma. There are need to educate patients and community on how to do IPC at home, how to limit mobilization and to do self-isolation when diagnosed with TB. There is a need to provide information using social media that are not intimidating and can persuade patients to get tested and treated. Interventions on mass screening in

	might help to handle issue on stigma. Screening activities in like in school or education institution, and in workplace can help to mainstream TB and prevent stigma. - Interventions for TB in workplace need further improvement to strengthen public health safety. The national guideline for TB treatment need revision related to the work safety. Tb are still not listed as work related disease and therefore there is no data of TB diseases in workplace. If we have data on TB in workplace that we can have better intervention for screening and providing TPT in workplace. Targeted screening in people with high risk group, including in workplaces with exposure to substance like silica may increase the TB case finding. TB screening should be included as part of requirement for entering workplace. Companies may have their internal regulation that require TB screening for new employees and to be part of annual medical checkup, but there is no regulation on this and no reporting standard for further interventions. Companies' clinics should be able to not only screen and diagnose but also treat and report Tb patients. - Currently there is no specific intervention or strategy to include and target vulnerable population with disabilities, transgender or people without national identity number. Among group with disabilities there are challenges in accessing health facilities in which they need pick up transportation and dedicated place that help them to access the service. There are program for Tb screening in prisons. Every districts should map their TB patients based on their demographic and work together with social and health office. - Presidential Regulation No.67/2021 are comprehensive and include all the recommended actions to TB elimination, yet the implementation need monitoring.

Date	14 July 2022
Respondent	Nurul Badriyah, Della, Aditiya Wicaksono
Institution	National TB Program, Ministry of Health
Topics	**Meeting Notes**
General Profile	- National TB Program under Disease Control and Prevention, Directorate of Communicable Disease Control, Ministry of Health is responsible for the coordination, implementation and monitoring the national TB strategy. One of the strategy to increase TB cases reporting and treatment is District Public Private Mix, in which the MOH engage and provide incentives for private hospitals and clinics.
Key Issues	- Implementation of Public Private Mix are in several level, mostly in District or City Level (District Public Private Mix or DPPM). Access to diagnostic and treatment are regulated by district/city government with Puskesmas as the head of PPM implementation in its areas. Role and job description of Puskesmas in DPPM is regulated with the Minister of Health Regulation that mandate health facility to be included in the network for TB services. - Puskesmas make MOU with private clinic in its area of work with information to the DHO. But there are variation in the MOU, as some Puskesmas have MOU with primary clinics for other diseases than TB, but some make MOU specifically for TB. The distribution for TCM referral based on workload are arranged by the DHO.

	- Before 2022, there was no option for private clinics to join DPPM. In the MOU before 2022, there was only description for role and jobs description for private clinics and for Puskesmas, and things that could be supported by Puskesmas. After 2022, the MOU was revised and made more specific hence the support could be in more details with addition jobs dan responsibility. - Currently there are 4 options to join DPPM: to refer patient for diagnostics and treatment, to refer sputum for diagnostics and provide treatment, to do the diagnostics and refer patients for treatment, to provide diagnostics and treatment. In providing diagnostics and treatment, patients can access national TB drugs in private health facilities only if the health facilities fulfil the requirement for reporting and monitoring. - The various "Options" regarding levels of service that providers may select are: 1) refer presumptive TB; 2) diagnose TB and refer for treatment; 3) diagnose and treat; 4) refer back to Puskesmas for treatment (after treatment initiation) - In providing access for diagnostics, private clinics must pack and send sputum sample and will receive compensation for specimen transport. Private health facilities can provide transport for specimen using internal transportation, or by using postal delivery services. On the implementation, every area use different type of delivery services, one of them is by using PT POS. For the transport specimen fee, Provinces made MOU with PT POS and use online application to track specimen. There are 18 Provinces in 132 districts who have had MOU with PT POS. The MOU include details for shipping, including fee for within city delivery, and baseline for TB RO specimen - Challenges with the PT POS include the timeliness for specimen collection. While in the MOU there's an agreement about how frequent they will collect and do specimen transport, many times there are delays that make health facilities deliver the specimen themselves using local transport. In Maluku Province they don't use PT POS service due to the high fare. - DPM clinic hardly access TCM using specimen transport delivery services. Since not all Puskesmas has TCM, many referral are from public health facility to another public health facility. Often patients are asked to deliver the specimen because health facilities are overwhelmed with their own workload to handle specimen transfer, that are considered complicated. - In the MOU with the PT POS, unit cost for specimen delivery is for each delivery. For example, the agreement prescribed for twice a week delivery, each delivery must include 6 samples or 3 patients if each patients send 2 samples. - Currently more clinics prefer the first option to prefer patient. There are problems with the capitation distribution. Clinics tend to send patient to other clinics with bigger capitation with more human resources providing TB treatment. Currently option to refer specimen is not attractive enough despite reimbursement for packaging and transportation. Incentive to get credits for CME also not attractive enough. Government are facing challenges in engaging private clinics not to only refer patient or specimens. - Current private clinics joining the PPM include that under BPJS-K or without BPJS-K network. In Medan, depend on the clinic commitments, several clinics take the option 4. Transport specimen using application will directly be delivered and recorded in SITB. Some DHO also actively promoting the DPPM to private health facilities.

	- MOH is publishing guideline for TB clinical service in primary care, which include service that can be delivered. Clinics are aware that current protocol for DPPM use bacteriological cases. - X-ray are done in hospital level. In primary care about 60% cases are diagnosed with bacteriology confirmation, while 40% with clinical diagnosis. - There are guidelines for transport and specimen handling, including packing SOP with video. Mechanism for waste handling also included in the guideline along with video presentation. The information about this guideline are disseminated in capacity building training targeting health facilities with Gene-Expert. Health facilities without Gene-Expert will learn only about SOP for specimen handling and packaging. The challenges in the implementation mainly in the collaboration with PT POS not in the specimen packaging or handling. Some health facilities are concern that the specimen are yet to be collected are piling up and, while unnecessary, put the specimen in the freezer. Private clinic might not receive training until they started to choose specimen referral. - Guideline for TB specimen handling and Lab: https://tbindonesia.or.id/pustaka-tbc/pedoman/lab-2/ - Requirement for clinics to have access to Government TB Drugs is to have MOU and to do case reporting since all logistics from the government must be monitored. Many clinics consider the reporting using manual form and with SITB are complicated and refuse to do so. - MOU are done between private clinics with DHO. When the clinic get access to treatment but do not do the reporting, access to treatment will be suspended and DHO will send out letter for the clinic to stop providing TB services. There are no TB medicine in the national formularies. - In approaching clinics, MOH offer benefit to health facilities such as support to increase capacity through online workshop and trainings. Trainings are limited due to budget constraints. MOH also provide logistics support as long as there's MOU in place and complete monitoring by the clinics. - Challenges with the community include there are no MOU between Puskesmas and community that link private clinics with Community. Community support is in the form of contact investigation, treatment monitoring and assistance, contact tracing for patient loss to follow up using Global Fund grant - PPM were started because there's under reporting and unreached population. PPM aims to solve issues on under reporting in private health facilities since there are many patients treated but yet to be reported. For the unreached population, contact investigation and active case finding are targeted to high risk population to have TB infection. Many active case finding are conducted by community using case index. There are also guideline for active case finding in prisons and in HIV patients.

Date	22 July 2022
Respondent	Ibu Ina – Cadre TB
Institution	Puskesmas Pegandan, Semarang
Topics	**Meeting Notes**
General Profile	• TB cadres do not specifically work for TB issues, but also deal with all health issues (DM, DBD, etc.) in one kelurahan area. Cadres are members of the Kelurahan Health Forum

	(*Forum Kesehatan Kelurahan – FKK)*. Each RW level (sub-wards) has 2-3 cadres average also to work on TB.
Key Issues	• Three tasks carried out by a TB cadre: a) accompanying patients to take medication until it is finished, b) socializing TB related to information about TB and its treatment to patients, families and communities, and c) collecting sputum samples. • Cadres receive trainings on TB (communication about TB to patients and families, sputum sampling, accompanying patients), not only once but there are refreshments carried out by Puskesmas. • If patients with TB went to get treatment to Puskesmas that does not cover the area where the patients live, usually the Puskesmas will refer to the related Puskesmas (Puskesmas covering the areas where the patients live) to be followed up, including by cadres. • There is no issue with peoples without ID card. There are no barriers to accessing TB drugs for people without ID card because usually local RT or RW will assist them with providing a domicile letter, even peoples who are not local residents (transferees) can access TB drugs. • Puskesmas through cadres have facilities to deliver TB drugs to patient's houses, especially for poor and disabled patients. • Cadres understand about the patient data confidentiality that the information about patients with TB should not be disseminated and only for tracking and treatment purposes (only for the designated cadres). Cadres have to sign a form regarding data confidentiality. Only because neighbors usually see cadres (along with puskesmas doctors and kelurahan staffs) visiting patients, so that neighbors know about the incidence of TB. TB patients and families often think that information was leaked by cadres or health workers. • Challenges faced in the field: a) patients are absent from treatment, b) patients do not know that they have TB (because of having other diseases such as DM), c) families do not admit (they know but do not admit because they feel disgraced or ashamed), d) families hide their family members with TB because of shame, e) families and patients who don't understand the risks of TB so they don't use masks. They don't understand that TB can be cured if treatment is complete, f) families don't want to take care of their family members, g) stigma from the neighbor who stay away for fear of getting infected. • Cadres get face masks from the puskesmas and there is incentive when collecting sputum. • Awareness education to the community on TB is important so that community understands information about TB, how to prevent it, do not conduct stigmatize, how to support patient with TB.

ANNEX 5. DISBURSEMENT LINKED INDICATORS (DLIS)

Indicator/Years	Results			
	Year 1	Year 2	Year 3	Year 4
Result Area 1 - Strengthened Subnational Tuberculosis Response				
1. A subnational fiscal transfer mechanism linked with TB key performance indicators is implemented	The design of performance-linked BOK includes TB notification and successful treatment being linked with appropriate type and magnitude of incentives – designed and implemented (2023); Manual for verification, and counter verification mechanism is developed (2023)	Performance-based payments forTB indicators at primary health care facility level have been paid in 2024 after due assessment and verification	Median performance scores on TB indicators at primary health care facility level in priority districts have improved by (TBD) percent between 2023 and 2025	No DLI; Implementation Completion
2. Improved supply side readiness, and strengthened payment mechanism	Improved readiness of primary health care facilities for TB services is included in BOK Puskesmas and JKN Capitation design (2023);	Updated Comprehensive TB Service Protocol and appropriate decision support tools (primary care, laboratory, and hospital) are made available; MOH has developed training modules for TB service delivery using new training approaches and digital technologies;	Training using revised modules completed by XX public and YY private providers (Note: numbers TBD)	No DLI; Implementation Completion
Result Area 2 - Strengthened TB care among private primary care health providers				

3. Strengthened logistics and regular sample transport mechanism	Logistics and mechanism for laboratory specimen transport is developed that will include the following steps: (i) Regulation review and revision to create enabling environment (ii) inclusion of centrally negotiated rates for transportation services in the e-catalogue (2023) Number of districts that have contracted service providers for specimen transport during the year (scalable, end target being a total of 80 percent districts by the end of the Program).	Number of districts that have contracted service providers for specimen transport during the year (scalable, a total of 80 percent districts by the end of the Program).	Number of districts that have contracted service providers for specimen transport during the year (scalable, a total of 80 percent districts by the end of the Program).	No DLI; Implementation Completion
4. Improved access to TB program drugs among private primary care providers	Logistics and arrangement to access TB drugs for private primary care providers is developed that will include (i) Development of the revised PPM design	Share of private primary care providers in the TB network have accessed TB Program drugs	Share of private primary care providers in the TB network have accessed TB Program drugs	No DLI; Implementation Completion

	for TB Treatment based on findings from the PPM Review; (ii) Commencement of contracting private primary care providers under the revised design to improve access to TB program drugs;			
5. Strengthened the payment mechanism links to the quality of service	New payment arrangement for primary care are implemented (i) Non capitation (Fee for Service) payment per fully treated TB case AND (ii) PKBK (Pembayaran Kapitasi Berbasis Kinerja - Performance-based capitation payment) to include notification, and successful treatment	InaCBG reform to modify hospital payments to provide a large part of the payment only when TB treatment is implemented	InaCBG reform to modify hospital payments to provide a large part of the payment only when TB treatment is implemented	
Result Area 3 - Enhanced digital systems for TB				
6. An integrated TB transaction-based information system	Simplified interface of the TB information system to notify TB cases is implemented	(i) Enhance the existing TB information system to have more automated data entry interfaces for data inputs;	Number of private primary care providers that have ever used the relevant TB program information system for TB notification during the year	No DLI; Implementation Completion

		(ii) Integration/Interoperability of all the existing TB application/information systems with IHS is established	(scalable, 80 percent of private primary care in the TB network in total by the end of the Program	
7. Improve use of data in decision making		The National TB Prevalence survey is implemented and used to estimate local-level TB prevalence At least two process evaluation of the newly introduced design features under this PforR are completed and published	At least two process evaluation of the newly introduced design features under this PforR are completed and published	No DLI; Implementation Completion

ANNEX 6. NATIONAL POLICY, LEGAL AND REGULATORY FRAMEWORK

Aspect	Policy/Law/Regulation	Assessment
TB Control Coordination	- The Presidential Regulation 67/2021 on TB Control - Health Minister Law 67/2016 on TB Control - National Medium Term Development Plan 2020-2024	The Presidential Regulation 67/2021, launched in August 2021, strengthen legal basis for TB response in Indonesia. The regulation also mandates the formation of acceleration team for TB elimination that consists of multi-sector ministers and national head agencies, with Minister of Health in charge of leading the planning, implementation and coordination of the nation-wide TB response. The Coordinating Minister of Human Development and Culture, along with the Coordinating Minister of Politics, Law and Security as Coordinating Minister of Economics, was leading as the supervisor for the acceleration team and to report directly to the President. The Presidential Regulation 67/2021 strengthen GOI's is in line with the Health Minister Regulation 67/2016 and National Medium Term Development Plan 2020-2024. The Health Minister Regulation 67/2016 on TB Control aim to eliminate TB in 2035 and to eradicate TB in 2050. The Heath Minister Regulation 67/2016 mandates both national and sub-national government to responsible in TB response health service deliveries. In the National Development Medium Term Plan, GOI targets the TB incidence rate to be 190 per 100,000 people in 2024, from baseline 319 per 100,000 people in 2017; and TB mortality rate to be 37 per 100,000 people in 2024 from 42 per 100,000 people in 2017. In the Presidential Decree 67/2020, GOI commits to eliminate TB in 2030 by reducing TB incidence rate to 65 per 100,000 people and TB mortality rate to 6 per 100,000 people.
TB Control Technical Guideline	- National Strategy for TB Control in Indonesia 2020 – 2024 - Guidelines for Tuberculosis Control in the Workplace, Ministry of Health and Ministry of Manpower 2015 - Minister of Health Decree 660/2020 on Mandatory Reporting of TB Cases for Health Care Facilities	The National Strategy for TB Response in Indonesia 2020 – 2024, launched by the Ministry of Health in 2020, provides strategies, interventions and target activities to achieve Indonesia's ambitious target to eliminate TB. The National Strategy for TB Response consists of six strategies: 1) Strengthening commitment and leadership of national and sub-national government; 2) Increasing access to high quality and patient centered TB services; 3)

Aspect	Policy/Law/Regulation	Assessment
	- Health Minister Decree 350/2017 on Hospital and Health Care Providers for MDR TB	Optimizing promotion and preventions efforts, as well as TB prevention treatment; 4) Utilization of research and technology for TB response; 5) Increasing involvement of communities, partners and multisector stakeholders; 6) Strengthening program management through health system strengthening. The National Strategy for TB response target three group of population based on access to TB services: 1) people with TB or TB symptoms that has not access health services; 2) People with TB that has access to health services but yet diagnosed or reported as TB patients; 3) People reported as TB patients but yet to be treated. However, during the Covid-19 pandemic some of the funding for health programs, including for TB program, were repurposed to finance the Covid-19 response at the national and sub national level. Other health system resources, such as human resource for health, medical supplies, and equipment, were mobilized and hence stretched the existing capacity to deliver essential health services including that for TB.
Hazardous Waste Management (HWM)	- The Government Regulations No 66/2014 on Environmental Health - MOH regulation No. 43/2013 regarding proper management of the clinical laboratory - MOH Regulations 46/2015 regarding accreditation for Puskesmas, Primary Clinic, Medical Doctor's and Dentist's Private Practice - MOEF regulation No. 56/2015 on Hazardous waste management in health care facilities - MOH Regulation 7/2019 regarding environmental health in hospitals - MOH Regulations 18/2020 regarding territory based medical waste management in health facilities	Based on The Government Regulations No 66/2014 on Environmental Health, HWM is part of the efforts to protect public health, in which HWM in health facilities, including clinics, laboratories and hospitals, must comply with the related Minister Regulations. The country's main framework on HWM is cast in Government Regulations No.101/2014 regarding Hazardous Waste Management, whereas the specific regulations on HWM in health care settings are prescribed in MOH Regulations 18/2020 regarding territory based medical waste management in health facilities. While the MOH Regulation 7/2019 regarding environmental health in hospitals regulates specific measures for HWM in hospitals level, MOH regulation No. 43/2013 regarding proper management of the clinical laboratory mandates specific measures for HWM in laboratories. Requirements on HWM are part of the hospital, clinics and laboratories accreditation criteria. The MOH makes it mandatory for all hospitals to get accredited by an independent accreditation body every three years, as well for Bio-safety level-2 (BSL-2) laboratory

Aspect	Policy/Law/Regulation	Assessment
	- Nuclear Energy Regulatory Agency Regulation No 4/2020 regarding radiation safety on the use of x-ray machine in diagnostic and interventional radiology - The MOH regulation No 24/2020 on Clinical Radiology Services	accreditation requirements. The primary health care accreditation, which include HWM, are required for all Puskesmas and clinics and regulated on MOH Regulations 46/2015. The further requirements on the management of air emissions from the medical incinerator are outlined in MOEF regulation No. 56/2015, in which the regulation set the technical specifications of the incinerator and the allowed emissions threshold MOH regulation No.7/2019 outlines the requirement to manage the wastewater from healthcare facilities, this includes the requirement to have wastewater treatment plant, conduct routine effluent monitoring, meet the effluent threshold requirements and report the monitoring to relevant government agencies. The effluent standard from the wastewater treatment plant prescribed in the MOEF regulation No. 5/2014 on the wastewater effluent standard.[6] The threshold set in the regulation is comparable with the performance standard set in WBH EHS Guideline for healthcare facilities (performance indicators for wastewater). MOEF Regulation No. 56/2015 requires wastewater from incinerators to comply with MOE regulation No. 5/2014. Nuclear Energy Regulatory Agency Regulation No 4/2020 regarding radiation safety on the use of x-ray machine in diagnostic and interventional radiology prescribes the requirements for radiation safety for all licensed x-ray user for diagnostic and interventional radiology. The requirements include aspects on management, protection from radiation, technical, and safety verification. This regulation prescribes requirements for x-ray license owner to provide protection toward radiation in workplace and to patients as well as healthcare facilities visitors. It also requires staffs that provides x-rays services to have health screening provided by the health facilities. Exposure to x-ray for patients must be justified with clinical indications, previous exposure, the benefit from having x-ray, dose appropriateness, and patient's conditions. The MOH regulation No 24/2020 on Clinical Radiology Services allows health facilities to provide x-ray services with sufficient facilities and human resources, including doctor specialized in radiology, radiographer, radiation protection and administration

Aspect	Policy/Law/Regulation	Assessment
		staff. Primary health services are limited to provide radiology services that include the use of mobile x-ray machine, dental x-ray and ultrasonography. The regulation also prescribes the standard requirement for having x-ray services from the building facilities to the providers' organization, service provided, monitoring and reporting, as well as quality control and assurance. While up to date the regulations limits most of primary health clinics from providing x-ray services, the PfoR need to ensure the system to monitor the implementation of standardized requirement for xray installment and usage are in place.
Occupational Health and Safety	- Law no 13/2003 on workforce - Law No. 36/2009 on Health - Government Regulation (PP) No. 50/2012 on Health and Safety Management - MOH regulation No. 43/2013 regarding Proper management of clinical laboratory - MOH regulation No. 66/2016 on Hospital's occupational health and safety - MOH regulation No. 27/2017 on infection prevention and control - Director General Decree on Health Services No 01.07/I/4596/2021 technical guidelines for infection prevention and control for drugs-sensitive- and multi-drugs-resistance TB in health facilities - Technical Guidelines for TB Infection Prevention Control in prisons by Minister of Law and Human Rights - Law No 36/2014 on Health Workers - Law No 12/2022 on Criminal Act towards Sexual Violence	Law no 13/2003 on workforce (article 35) protects workers in general by mandating employer to protect worker's well-being, safety, physical and mental health. Law No. 36/2009 on Health (section XII) and Government Regulation (PP) No. 50/2012 on Health and Safety Management require hospitals and other health care facilities to oversee and ensure the workers' safety and health by implementing an OHS management system. MOH regulation No. 66/2016 on Hospital's occupational health and safety provides specific guideline on how to implement the management system in hospitals, which include risk management, OHS practices, waste management, fire prevention, mandatory immunization for workers, mandatory training, availability of PPE, among others. The requirements prescribed in this regulation are harmonized with relevant GIIP such as the WBG EHS Guidelines for healthcare facilities and WBG EHS General Guidelines for OHS. MOH regulation No. 27/2017 on infection prevention and control, align with WHO publications related to infection prevention and control guidelines, covers detail building construction requirement, zoning guideline, safe practices, appropriate PPE for workers, among others. MOH Regulation No. 27/2017 mandates basic requirements on facility location, building standards, ancillary facilities (laboratory, blood banks, temporary waste storage), disinfection and sterilization

Aspect	Policy/Law/Regulation	Assessment
		of equipment, sanitation services, staff competency and monitoring and evaluation to ensure the health and safety of patients, especially to prevent nosocomial infections at the facility. MOH regulation No. 66/2016 on hospitals occupational health and safety and MOH regulation No. 27/2017 on infection prevention and control cover health care workers, patients and visitors of the hospitals. MOH regulation No. 43/2013 regarding Proper management of clinical laboratory provides comparable requirements to ensure OHS management in laboratories is also in line with WHO's laboratory biosafety guidance. National Strategy for TB Control calls for efforts to strengthen IPC that include revision for TB IPC guideline from 2012, trainings and capacity buildings for health care workers, periodic screening for healthcare providers, public education, multi-sector collaborations for IPC in communities including in houses, boardings, prisons and workplaces. Efforts to provide TB IPC in congregate settings include implementation Technical Guidelines for TB Infection Prevention Control in prisons by Minister of Law and Human Rights, which prescribed regulation, planning, education and information and standard ventilations. However, requirements to ensure implementation, like that in the accreditation process for health care facilities are not in place. MOH launched guideline for MDR TB care in Indonesia in 2020 that prescribed IPC specifically for MDR TB in health facilities. Law No 36/2014 on Health Workers (Article 57) stated all health care providers have the rights to work in a safe and respectful working environment. The Law also stated that health care providers must oblige to code of ethics from each of the Medical Council, which have the obligations to investigate, process and decide on penalties if there's any complaints from the society which proof violations to the code of ethics.

Aspect	Policy/Law/Regulation	Assessment
		Law No 12/2022 on Criminal Act towards Sexual Violence include sanctions for any sexual harassment, with additional period of sanctions if the act was acted by health care providers. Article 15 on that Law specifically stated that criminal sanctions for sexual harassment or violence will be added by one third, if it was acted by health care providers, medical professional, education providers or professional which has the mandates to provide care, protection and rehabilitation.
Equitable access for TB care	- The Constitution of 1945 Article 28 A - Law No. 8/1999 on Consumer Protection - Health Law 36/2009 - MOH Decree No 350/2017 regarding Hospital and Health Care Providers for MDR-TB - MOH Decree HK 01.07/Menkes/755/2019 regarding clinical guideline for TB treatment, protocols or guidelines to target specific group - MOH Law No 4/2019 regarding Technical Standard for Primary Care Quality Assurance on Minimum Health Services Standard	The Constitution of 1945 Article 28 A and Health Law 36/2009 guarantees the rights of all Indonesian citizens to have equal opportunity to health, including to access healthcare that are safe, high quality and affordable. Through its constitution and Law, GOI guarantees the protection of citizens' rights to be align with human rights, gender equality, non-discriminative, and equity principles. Based on Law No. 8/1999 on Consumer Protection, all citizens have the rights to choose health services, to be treated without discrimination, to have access to information regarding services, to be heard, to be treated with fairness and have legal access to litigation. The law also protected access to health services for people with disabilities, in which health care providers must ensure that health services and facilities are accessible and non-discriminatory. Patients and families should have access to information regarding illness, treatment, prognosis and alternative treatment regardless of request for information. MOH Decree HK 01.07/Menkes/755/2019 include specific clinical guideline for people with high risk for TB infection including people with HIV/AIDS. The MOH Decree No 350/2017 regarding Hospital and Health Care Providers for MDR-TB mandates 260 hospitals, mostly public hospitals, spread in 34 Provinces to provide health services for MDR TB MOH Law No 4/2019 regarding Technical Standard for Primary Care Quality Assurance on Minimum Health Services Standard mandates all primary care clinics must provide health services for TB.

Aspect	Policy/Law/Regulation	Assessment
Social stigma	- Law No. 39/1999 Regarding Human Rights - The Law No 13/2003 on workforce - MOH Regulation No. 67/2016 on TB Control - Presidential Regulation No.67/2021	Law No. 39/1999 Regarding Human Rights that calls for citizens' protection from all kind of discrimination. The Law No 13/2003 on workforce protects job security for TB patients by prohibiting employees termination due to sick absence less than twelve months in a row MOH Regulation No. 67/2016 on TB Control calls for public participation in the TB elimination efforts by reducing stigma and discrimination of TB patients in the community Presidential Regulation No.67/2021 mandates that all TB patients to be protected against stigma and discrimination. The regulation further state that efforts to prevent social stigma and discrimination is part of the communities role in the partnership with the government. The Presidential regulation calls for alignment and implementation of policy that will reduce stigma and discrimination among vulnerable and high-risk TB population.
Medical information, data privacy and security	- Indonesia has 32 laws and regulations which govern the protection of personal data/ privacy. Six of those are related to health sector include Law No 29/2004 on Medical Practice, Law No 36/2009 on Health, Law No 44/2009 on Hospital, Law No 18/2014 on Mental Health, and Law No 35/2009 on Narcotics - Law and Regulation on personal data protection related to the use of electronic medical record, which include Law No.11/2008 on Information and Electronic Transaction, Government Regulation No. 71/2019 on the Implementation of Electronic System and Transaction, Presidential Regulation No. 95/2018 Electronic Based Government System, Minister of Communication and Information Regulation No. 20/2016 on Data Privacy Protection on Electronic System, Law No. 36/2019 on Health, Law No 9/2004 on Medical Practice, Law No 44/2009 on Hospitals, Government Regulation No 46/2014 on Health Information System. - Minister of Health Regulation No.269/MenKes/Per/III/2008 on Medical Records	Article 57 (2) of Law, No 36/2009 on health, stated that exception on data protection could be made in several conditions include for public health interest by respecting the necessity and proportionality principles. Patients' data privacy and confidentiality are protected by Law No 36/2014 regarding Healthcare Providers article 73 and by Law No 44/2009 article 38 on Hospitals that mandates healthcare workers and hospitals to keep patients' data confidentiality. Law No 36/2009 on Health and Law No. 29/2004 on Medical Pratice state that all citizens have the right to receive information and education about their health, including any intervention and medication. All healthcare providers must provide all medical information's regarding patients' conditions, treatment options and its effect, and possible consequences related to patients' conditions. MOH Regulation No 269/2008 on Medical Record Article 2 allows medical record in the form of electronic. Minister of Health Regulation No. 269/MenKes/Per/III/2008 on Medical Records and MOH Regulations No. 36/2012 article 5 regarding patients' confidentiality stated that all health facilities must maintain the confidentiality of the patient's medical records

Aspect	Policy/Law/Regulation	Assessment
	- MOH Regulations No. 36/2012 regarding patients' confidentiality - Minister of Health Decree 660/2020 regarding Mandatory Reporting of TB Cases for Health Care Facilities	except for extraordinary circumstances for health and safety reasons, law enforcement, at the request of the patient(s) concerned, and for research and education purpose without disclosing the patient's identity. While patients' rights for informed consent and data privacy is protected under Law on Health no. 36/2009 article 56-57, it can also be waived over public interests to prevent the spread of infectious disease in communities. This suggests that consent requirements for the purpose of tracing, testing and treatments for TB are not mandatory requirements. Under ordinary circumstances, protection of patients' confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek for the second opinion prevails prior to any medical treatment. Minister of Health Decree 660/2020 regarding Mandatory Reporting of TB Cases for Health Care Facilities mandates all healthcare providers to report TB cases using MOH's Tb information system.
Public Information Disclosure Feedback and Grievance Redressed Mechanism	- Law No. 14/2008 on Public Information - Law No 12/2005 on ratification for international covenant on civil and political rights	Law No. 14/2008 on Public Information and Law No 12/2005 on ratification for international covenant on civil and political rights mandate citizens' rights to access information and disclosure through public information is open and accessible by the public user other than exception information.