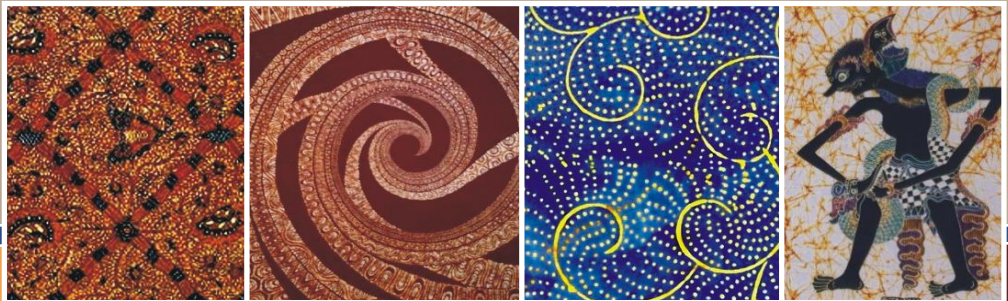


WHO Country Cooperation Strategy 2007-2011



Indonesia



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Country Office for Indonesia

WHO Country Cooperation Strategy 2007–2011

Indonesia

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Preface

The collaborative activities of the World Health Organization in the South-East Asia Region aim to improve the health status of populations in Member countries of the Region. The WHO country cooperation strategies help to identify how WHO can best support health development in its Member countries.

Indonesia was one of the first countries to develop a country cooperation strategy, covering the period 2001-2005. However, since its preparation, many changes have taken place in the country. These include reporting of cases of avian influenza in poultry and subsequently in humans, a polio outbreak and the tsunami and other natural disasters, as well as progress in the government's own health development efforts and those of its key partners. Therefore, it is appropriate that WHO has now prepared a new country cooperation strategy covering the period 2007-2011. An analysis of the current health situation; likely health scenarios up to 2011; and new priorities of the Ministry of Health and the World Health Organization form the bases for priorities outlined in this strategy.

We recognize the need for a strong WHO country office to work closely with key Indonesian counterparts, keeping in mind local conditions and emerging priorities such as noncommunicable diseases. This will help us achieve the objectives of this country cooperation strategy. In addition, the WHO Regional Office and WHO headquarters are fully committed to further support the country office in implementing this strategy.

I would like to thank all those who have contributed to developing this WHO country cooperation strategy, for the implementation of which the WHO Regional Office is fully committed. We appreciate the inputs and suggestions received from the Ministry of Health, key health experts and our health development partners in the country. It is this consultative process that will ensure that WHO inputs provide the maximum support to health development efforts in Indonesia over the next five years. Our joint efforts should be aimed at achieving the maximum health benefits for the people of the world's largest archipelago.



Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director

November 2007

Foreword

The global WHO corporate strategy, developed in 2000, constituted a new departure for the Organization. It entailed, *inter alia*, the development of WHO country cooperation strategies to foster a corporate and more strategic approach to country work. Developed in 2000, the WHO country cooperation strategy for Indonesia 2002-2005 was one of the first five strategies to be implemented by Member countries of the WHO South-East Asia Region. However, it was anticipated that country cooperation strategies would be updated as conditions changed.

WHO's new country cooperation strategy for Indonesia 2007-2011 was developed in close collaboration with the Ministry of Health, development partners and civil society, by a team consisting of colleagues from WHO headquarters, the Regional Office and WHO country offices. Successive briefing and consultative sessions were held with national and international partners in health and other sectors. The team reviewed national, rural, sectoral and sub-sectoral health plans, implementation reports and latest information available. I wish to acknowledge the team's and my predecessor's contribution in developing this document.

The first WHO country cooperation strategy for Indonesia had identified six principal components. Following review and update, these evolved into the following six strategic areas for the WHO country cooperation strategy 2007-2011: health policy and systems development; prevention and control of communicable diseases; health of women, children and adolescents; noncommunicable diseases, mental health, health and development; emergency preparedness and response; partnerships, coordination and WHO's country presence. Furthermore, a set of strategies were identified for each of these areas, to guide implementation of WHO's collaborative programmes in the country.

WHO wishes to acknowledge the valuable contributions of all its partners. We express our sincere gratitude for the time and input by the Ministry of Health, the United Nations system, as well as national and international stakeholders, and trust that these efforts will help in bringing health benefits to the people of Indonesia.

November 2007



Dr Subhash R. Salunke
WHO Representative to Indonesia

Introduction

The World Health Organization (WHO) introduced the formulation of WHO country cooperation strategies (CCS) in 1999 as part of the Organization's new corporate strategy. In 2000, a WHO country cooperation strategy for Indonesia was among the first to be developed, covering the period 2001-2005. In line with WHO's global and regional policy frameworks and following an assessment of WHO's comparative advantage, the Organization's country cooperation strategy for Indonesia was revised and updated, outlining directions and priority areas that WHO will focus on during the period 2007-2011. In effect, it is a corporate attempt to outline WHO's business plan in the country, in support of national health development. In doing so, the Organization will adhere to the functions that have been mandated by its governing bodies, i.e. providing policy and technical support; catalysing change and building sustainable institutional capacity; engaging in partnerships; monitoring the health situation and assessing health trends; setting norms and standards and monitoring their implementation; and shaping research and disseminating knowledge. In addition, the WHO CCS for Indonesia will serve as a guiding document in the development of the Organization's collaborative country workplans with national health authorities.

The period 2001-2005 witnessed significant changes in the health sector in Indonesia. The political and socioeconomic decentralization process initiated in 2000 has had a tremendous impact on the national health system. Provinces and districts now develop and budget their own health plans independently with funds they generate themselves and with funds they receive from the Ministry of Finance. This arrangement has considerably weakened the unified national health system, including the once well-established disease surveillance system, as well as other public health programmes.

However, the *Healthy Indonesia 2010* goal set by the government and the increasing importance paid to the UN Millennium Development Goals (MDGs) and their health-related targets are milestones in the process of national health development. Indonesia has been successful in mobilizing resources for health during the last two bienniums, including funds provided by the Global Fund to combat AIDS, Tuberculosis and Malaria (GFATM) and other sources. This has created new challenges for the health sector to strengthen capacity to absorb and utilize mobilized resources. This is important to optimize the benefit from such resources to address priority issues of the health system, while focusing on the poor and marginalized sections of society. The

country faces additional challenges, as exemplified by the emergence of Severe Acute Respiratory Syndrome (SARS) in 2003 and of avian influenza in 2004, by the reintroduction of poliomyelitis in 2005 after a decade of absence, as well as reconstruction and rehabilitation following the unprecedented tsunami disaster of 26 December 2004. Furthermore, other natural disasters — earthquakes, seaquakes, volcanic eruptions and floods — demand attention.

All the above developments have put added pressure and additional expectations on WHO as well. They have underlined the need to revisit the original CCS for Indonesia, in order to maximize WHO collaboration and contribution. In March 2004, the first consultative meeting was held with the WHO country team to begin the review. Subsequent meetings were held during May and December 2005. These consultations recommended that the priority areas identified in the original CCS be retained and that they form the starting point to bring the CCS for Indonesia up to date. A thorough revision of the content was undertaken in the light of the above developments.

During April 2006, a mission consisting of colleagues from global, regional and country levels of the Organization joined the country team to finalize the WHO CCS for Indonesia 2007-2011, in a series of consultations with a wide range of stakeholders from the Ministry of Health, civil society and other bilateral, multilateral and nongovernmental partners in health. Numerous comments and suggestions have been taken into account in producing the present corporate document: WHO's country cooperation strategy for Indonesia 2007-2011.

People and government: health and development challenges

2.1 Background on Indonesia

Geography

The Republic of Indonesia, which consists of approximately 17 000 islands, is located between Asia and Australia. There are five major islands: Sumatra, Java, Kalimantan, Sulawesi and Irian Jaya or Papua, bordering with Papua New Guinea. Two remaining groups of islands are Maluku and Nusa Tenggara, running from Sulawesi to Papua in the north and from Bali to Timor in the south. Other islands are small and mostly uninhabited. More than 80% of Indonesia's territory is covered with water; the land area is about 1.9 million square kilometers. The population at the census in 2002 was approximately 220 million people.

The large number of islands and their dispersion over a wide area has given rise to a diverse culture and hundreds of ethnic groups, each with its own language, though the national language, Bahasa Indonesia, is a unifying factor. Indonesia's climate is tropical with two seasons, the dry season (May to October) and the rainy season (November to April).

Governance

Indonesia is administratively divided into provinces and districts. Between 2001 and 2006, the number of provinces expanded from 27 to 33. Each province is subdivided into districts — the decentralized administrative unit, and municipalities. In 2006, there were 440 districts and 91 municipalities. Additional administrative units were sub-districts and villages. There were 5 263 sub-districts and 62 806 villages in Indonesia in 2006 (Ministry of Home Affairs, Indonesia).

Indonesia proclaimed independence from several centuries of colonial rule on 17 August 1945. Since then, the country has experienced several profound political developments. Indonesia's founder president, Dr Soekarno, was succeeded by President Soeharto in 1966. A *new order government* was established, oriented towards directed overall development. A period of uninterrupted economic growth was experienced from 1968 to 1996, when the per capita income increased sharply from about US\$ 50 to US\$ 385 in 1986, and to US\$ 1124 in 1996, as the national economy

expanded at an annual average rate of nearly 5%. This experience was abruptly reversed by the economic crisis that affected South-East Asia in 1997.

In 1997 and 1998, Indonesia went through its worst economic crisis since independence. Economic growth reversed, to a negative 13% (BPS, 2003). After more than three decades in power, President Soeharto resigned in 1998. The political situation underwent rapid transition. Soeharto's last vice-president, B J Habibie, succeeded him as President from 1998-1999. Further changes of national leadership followed. President Abdurrahman Wahid was in office from 1999-2001. President Megawati Soekarnoputri, daughter of the country's first President Soekarno, led the government from 2001-2004. Historic presidential elections took place in October 2004, direct for the first time, when the current president, HE Susilo Bambang Yudhoyono, came to office. Since 2000, the economy has been growing at an annual rate ranging between 4% and 6%. Health and education have received more attention, as reflected in the increasing national budgets for these sectors.

United Nations Millennium Development Goals

In September 2000, at the United Nations (UN) Millennium Summit, the Government of Indonesia signed the Millennium Declaration and committed itself to work towards the attainment of the UN Millennium Development Goals (MDGs). This commitment is reflected in the national development plan *propenas* and in strategies to reduce poverty — at national and sub-national levels — aimed at achieving these goals.

Decentralization – transfer of administrative authority

Decentralization was implemented in 2001 following new rules for fiscal transfers between different levels of administration. The decision to decentralize administrative authority directly to district governments created confusion regarding the roles of different levels of administration in health development, the provincial level in particular. Districts were given full discretion in prioritizing sectors for development. In many districts health problems did not get sufficient attention or funding, as reflected by the near collapse of surveillance systems, one of the backbones of disease control. Acknowledging this situation, renewed efforts were made by the government to address implementation issues by revising the legislation governing decentralization in 2004. It is expected that the new laws and regulations will better address the problems of implementation of decentralization.

Health priorities and programmes

The Health Law number 23, enacted in 1992, provided the legal basis for health sector activities. It stipulated that the goal of health programmes and development is to increase awareness, willingness and ability of everybody to live a healthy life. The law emphasizes the decentralization of operational responsibility and authority to the



local level as a prerequisite for successful and sustainable development. In 2000, the People's Assembly (MPR) amended the 1945 Constitution of the Republic of Indonesia to include the right of every citizen to live in a healthy environment and have access to health services and social insurance.

In mid-September 1998, a new health paradigm was introduced that focused more on health promotion and prevention rather than on curative and rehabilitative services. The new vision was reflected in the motto *Healthy Indonesia 2010*. In October 1999, the Ministry of Health presented the *Health development plan towards healthy Indonesia 2010*, which outlined the following goals:

- To lead and initiate health-oriented national development;
- to maintain and enhance individual, family, and public health, along with improving the environment;
- to maintain and enhance the quality, equitability and affordability of health services; and
- to promote public self-reliance in achieving good health.

In November 2005, under the auspices of the coordinating Ministry for People's Welfare, the Government of Indonesia held a national health conference to raise awareness among high-level political leaders and health authorities at all levels, of the high priority attached to health by the government. Following the conference, the Minister of Health launched a new policy platform for national health development at a meeting of health partners in December 2005. External partners were invited to participate in and support the development of the policy platform.

As a follow-up in March 2006, the Ministry of Health issued a new *Strategic plan 2005-2009* emphasizing the new vision "self reliant communities to pursue healthy living" and its mission "to make people healthy". The values underlying the vision and mission include: being people-oriented, rapid and appropriate response, teamwork, high integrity, and transparency and accountability. The four pillars or priorities that form the basis of the new health approach are:

- (i) **Social mobilization and community empowerment**, including promotion of proactive participation of individuals and communities in their own health care and the promotion of the *desa siaga*, or village preparedness programme.
- (ii) **Improvement of community access to quality care services** through revitalization of the basic health system, development of effective and efficient networks, implementation of health sector quality assurance and improvements in the number and quality of human resources. Increasing access and quality of health care should be supported by adequate healthy administration, laws and regulations as well as health research and development.

- (iii) **Improvement of surveillance, monitoring and health information system** through active community participation in reporting health problems, mobilization of funds and human resources in emergency situations, improvement of early warning system and implementation of the national pandemic preparedness plan. Health information systems at all levels need to be revised and strengthened.
- (iv) **Increase in health financing** through identification of funds to ensure availability of resources for health; advocacy to all stakeholders in both public and private sectors; gradually increasing public financing to 15% from national and regional state budgets. Furthermore, social health insurance will be extended, starting with the implementation of a programme providing subsidized insurance for the poor.

2.2 Health profile

By the early 1990s, Indonesia had experienced an improvement in socioeconomic indicators. Life expectancy at birth reached 69 years (67 years for males and 72 years for females) in 2005 and the infant mortality rate gradually declined from 68 per 1000 in 1990 to 32 per 1000 in 2005. The proportion of population living in poverty dropped dramatically from 60% in 1970 to an estimated 17% in 2004 and the literacy rate for those aged 15 years or more was 91% in 2004. However, these achievements received a setback in mid-1997 with the economic crisis. Although the health status of Indonesians was not affected drastically in the short term, the proportion of people living in poverty rose during the period of political, economic and social instability. Most recently, poverty rates have again been reported to have declined.

Indicators show that the health situation of mothers, children and adolescents in Indonesia still has much room for improvement. Wide geographical variation exists for infant and maternal mortality. Mortality rates for children (less than five years) and infants (under one year) remain at 46 and 32 deaths per 1000 live births, respectively, although a reduction in under-five and infant mortality rates reflects progress. Nevertheless, persistent rates of death among Indonesian children within the first year of life, one third of which occur within one month after birth, are a reflection of the quality of health care during prenatal, delivery and postnatal periods. Indeed, all three major causes of infant mortality — acute respiratory infections, perinatal complications, and diarrhoea — could be considerably reduced through quality health prevention and care.

All estimates confirm that the maternal mortality ratio (307/100 000 live births) in Indonesia is among the highest in the South-East Asia Region (*Indonesia Demographic and Health Survey 2002-2003*). The lifetime risk of a mother dying of causes related to childbirth is estimated to be 1 in 65 — compared with 1 in 1100 in Thailand (WHO 2002). In Indonesia, 58% of deliveries are estimated to take place at home; of



those, 33% are in urban and 67% in rural areas. The rate of caesarean sections, one of the life-saving interventions in obstetrics, is 2% in rural and 7% in urban areas. Over-medicalization of deliveries is a concern in cities, while in rural areas the majority of women in need have no access to emergency services. The Ministry of Health has made advances in addressing maternal mortality by focusing on the three main areas outlined in the national 2001-2010 making pregnancy safer strategy, i.e.:

- Skilled attendance at delivery;
- access to hospital care in case of complication; and
- prevention of unwanted pregnancy and unsafe abortion.

There has been a decline in fertility in Indonesia from 3.0 children per woman of reproductive age in 1988-1991 to 2.2 children per woman in 2005. Compared with some countries in South-East Asia, the total fertility rate in Indonesia is relatively low and a decline has taken place in most provinces. It is vital to sustain and build on these achievements. The median age at first marriage for girls is 20.2 years. While median age at first birth is 21.9 years, 16% of childbearing women are 18 years or younger. In addition, 11% of total fertility is attributable to births by the 15-19 year old age group (*Indonesian demographic and health survey 2002-2003*). Maternal, under-five, infant and neonatal mortalities are higher among mothers under the age of 20 compared to mothers above that age. These data demonstrate the importance of reproductive as well as adolescent health.

Communicable diseases continue to be the major cause of morbidity and mortality in Indonesia. Nearly 300 people die of tuberculosis (TB) every day, with over half a million new cases estimated to occur every year (WHO report 2006: Global tuberculosis control – surveillance, planning and financing). Malaria remains a major vector-borne disease in many parts of Indonesia and large-scale outbreaks of dengue and dengue haemorrhagic fever are reported every year. Although leprosy has been eliminated at national level, Indonesia ranks third in terms of the global burden. It has overtaken Viet Nam in the number of deaths from avian influenza, with a case fatality rate in 2006 nearing 75%. The potential for origination of a pandemic is real. The re-introduction and spread of poliomyelitis in several provinces, after a period of 10 years, has pointed to weaknesses in the routine expanded programme of immunization (EPI). Thus the burden of communicable diseases — and the possibility of emerging diseases with epidemic or pandemic potential — are a major concern. Responding effectively to these complex disease patterns and potential threats to health is likely to remain a major set of challenges for the country during the coming years.

The HIV epidemic directly affects the most productive members of the society: the young people and wage-earners. At the end of 2003, an estimated 53 000 to 180 000 Indonesians were living with HIV-AIDS (UNAIDS 2004). The number of HIV-infected intravenous drug users (IDUs) increased rapidly from 16% in 1999 to

43% in 2003. The primary mode of HIV transmission is at present injecting drug use. As of December 2005, 4700 people living with AIDS (66%) are on, or have received, antiretroviral therapy treatment (Directorate General of disease control and environmental health, Ministry of Health, Indonesia).

An epidemiological transition towards noncommunicable diseases (NCDs) is becoming a major problem and an additional challenge for Indonesia. This added burden of disease, associated with high levels of morbidity, is not limited to affluent populations in urban settings alone, but is also affecting poorer people, reducing their earning capacity and as such contributing to further impoverishment. Chronic conditions such as cancer, cardiovascular diseases, metabolic disorders and tobacco dependence represent a real burden to the country in terms of cost, suffering and human lives. In addition, Indonesia has a backlog of about two million cataract cases, leading to blindness, which needs to be addressed to reduce the social burden. NCDs are heading towards becoming a major public health problem, requiring sustained prevention and control of the risk factors involved. Indonesia has adopted WHO's global strategy in prevention and control of NCDs. However, the major challenge ahead will be to implement the strategy and to develop multisectoral public policies in support of the strategy.

In view of the high prevalence of tobacco use in the country and given the fact that for noncommunicable diseases (NCDs) tobacco is the second most important cause of morbidity and mortality, development and implementation of an effective tobacco control programme will be emphasized. Under the Bloomberg global initiative to reduce tobacco use, efforts will be made to ensure that this initiative contributes to strengthening the tobacco control programme in the country. However, the most important challenge for Indonesia in the area of tobacco control is likely to be its accession to the WHO Framework Convention on Tobacco Control, as fellow countries of the Association of Southeast Asian Nations and of the WHO SEA Region have already done. While further support is required to achieve a majority in Indonesia's legislative assembly, a considerable number of parliamentarians are already lobbying for the country to join the Framework Convention.

Mental health has long been neglected, despite an estimated 12.3% loss of productive days due to mental and neurological disorders. This situation was further aggravated by the tsunami of 26 December 2004, which substantially impacted the mental health of affected populations. It soon became clear that a large number of people were suffering from afflictions ranging from mild psychological distress to severe mental disorder. An additional, increasing problem among children and adolescents is that of substance abuse, while social unrest, conflict and acts of terrorism add further burden to the mental health problem in the country. The Ministry of Health recently shifted its paradigm from a hospital or institution-based mental health approach to one that is more community-based. However, a much-needed, comprehensive mental health service delivery system is not yet in place. Successful implementation of

the new policy direction will require substantial development of capacity, new and existing, in the health sector.

Environmental determinants of health are an important issue in Indonesia. Considerable air pollution resulting from extensive burning of fossil fuels, use of leaded gasoline in cities and major forest fires throughout Indonesia impact negatively on public health. Indoor air pollution resulting from excessive use of biomass fuel in poorly ventilated households, combined with unreliable or intermittent supply of safe water and inadequate sanitation, have led to dangerous levels of household pollution in some areas.

Indonesia is prone not only to natural disasters like seaquakes, volcanoes and earthquakes, but also to human-induced disasters, resulting in deaths and disabilities for many people. It is exceedingly difficult for the country's health care system (as it would be for any health care system) to deal adequately with mass casualty incidents, or the many needs of internally displaced persons. The impact of the unprecedented tsunami — with hundreds of thousands of dead and missing people, nearly half a million displaced persons and the destruction of infrastructure and systems — tragically highlighted the importance of national and local emergency preparedness. There is an urgent need to improve community preparedness for disasters as well as the health sector response to emergencies, at district, provincial and central levels.

2.3 Health systems

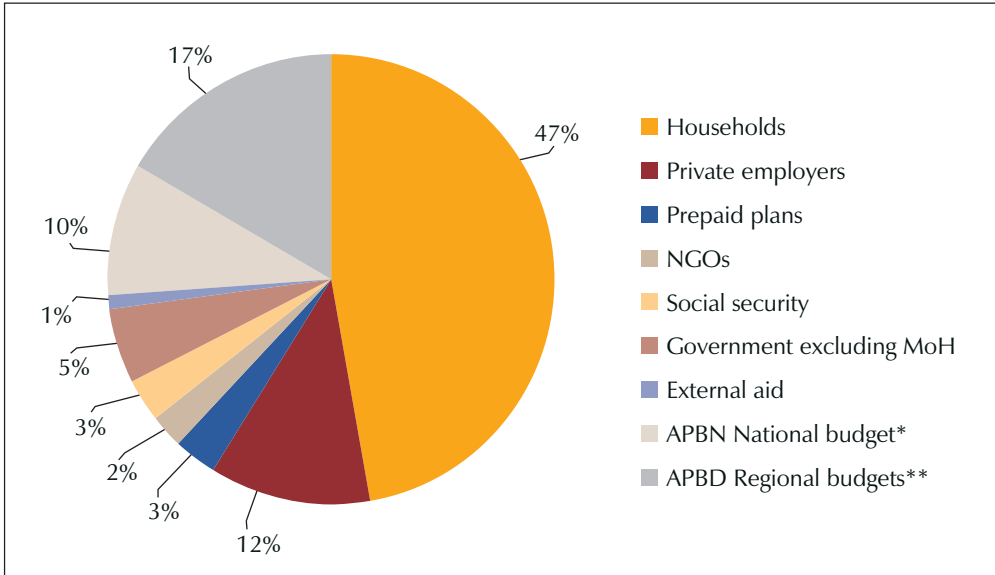
The general decentralization process implemented in 2001 has had many impacts on the health system, even though it was not designed specifically with the health sector in mind. In particular, health financing, health information systems, human resources for health and service provision have been affected. Under decentralization, the responsibility for health care provision is largely in the hands of regional governments.

Health financing

Compared with neighboring Malaysia and Thailand, Indonesia spends relatively little on health services. The estimated total expenditure on health per capita in 2003 was US\$ 33 in Indonesia compared with US\$ 149 in Malaysia and US\$ 90 in Thailand (all figures in US dollars at the then-prevailing exchange rates; Indonesia public health expenditure review, 2004). Within that, public sector spending on health per capita, in 2003 was estimated at US\$ 11 in Indonesia, US\$ 80 in Malaysia and US\$ 63 in Thailand. Part of the discrepancy is explained by the fact that Malaysia and Thailand are richer countries, but another part is explained by the fact that they accord a higher priority to health. Public expenditure on health as a share of the national economy was 1.2% in Indonesia, compared with 2% in Malaysia and 3.1% in Thailand.

The overall health financing situation in Indonesia is complex and incompletely documented. As shown in figure 1, around 36% of total expenditure is undertaken

Figure 1: Health expenditure by source of financing, 2006



Source: Adapted from Indonesia's National Health Accounts, 2006

* APBN stands for *Anggaran Pendapatan dan Belanja Negara*

** APBD stands for *Anggaran Pendapatan dan Belanja Daerah*

by public sector agencies, while 64% is private. By far the largest single source of private expenditure is direct out-of-pocket payments by households, accounting for nearly half of the total expenditure. Services provided privately are largely financed by out-of-pocket payments, with some insurance and employer-financed expenditure benefiting a minority of formal sector employees. Publicly provided services are financed by a mix of public budgets and user fees, in turn financed by a combination of households, employers and insurers. Until the advent of the new social insurance scheme for the poor, described below, insurance coverage of the population was low at (well under 10%).

Historically, a highly inequitable pattern of health financing has been observed. Distribution of household expenditures is even more skewed in favour of upper-income groups than the distribution of incomes itself. This reflects low utilization of health services by poor people and low use of public hospitals. The coverage of insurance, or direct employer-paid benefit, is confined to a minority of formal sector employees. Public budgets are distributed inequitably between geographical areas, while the benefit-incidence analysis showed implicit subsidies were captured largely by higher income groups. Since 2005, a new non-contributory scheme has been designed to provide state-subsidized health insurance for poor households, using the civil servants' scheme as insurance carrier. This is an important and positive initiative, which may begin to address some of the above problems. Careful evaluation of the

scheme will be required to determine the extent to which it improves access to quality services for the poor, and whether it is adequately funded.

A larger proportion of budgeted public expenditure now appears in district budgets, up from 10% (prior to decentralization) to 50%. In part, this merely reflects the transfer of responsibility for meeting salaries of civil servants from central to regional governments. A large proportion of programme operating expenses continue to be provided in a tightly earmarked fashion to regional governments from the decentralized component of the national-level budget. This national budget has risen strongly in recent years (from a very low base), largely reflecting additional spending from the decentralized component and the new commitment to provide insurance coverage for the poor. In 2006, as depicted in Figure 1, Indonesia's health sector was not heavily dependent on external inflows, which accounted for less than 2% of the total expenditure. The inflows constituted a large share of public financing (6%), and a larger share still of public financing at central level (16%). However, 2002 probably marked a low point in external inflows, which had risen markedly during the economic crisis of 1997-2000 before declining. The inflows rose again in subsequent years, with the inception of new sources of funding, such as the Global Alliance for Vaccines and Immunization (GAVI) and Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM).

Health information systems

Decentralization resulted in a partial breakdown of health information systems and led to an unclear division of reporting responsibilities. As a result, comprehensive data that cover the entire nation are not available. The disruption of the information flow makes it difficult to develop strategies and monitor health programmes in provinces and districts. However, exceptions do exist in some vertical programmes (tuberculosis, malaria or HIV/AIDS) where the Central Government retains the responsibility as the principal recipient of GFATM grants to the country.

Human resources for health

The human resource situation in health has major deficiencies in numbers and quality of the health workforce. Decentralization is one of many factors exacerbating long-standing problems with maldistribution and reportedly low productivity of health workers. Under decentralization it has become harder for civil servants to be redeployed and move across different levels of government. Other factors complicating management of the public sector workforce include poor incentives, widespread dual practice and expansion of the private sector in health services and educational facilities. The relatively low quality of the workforce is partly attributable to the lack of strong accreditation and licensing procedures. This in turn impacts on the quality, efficiency and equity of health care provision.

In 2001, the Ministry of Health reorganized its human resource functions. A new Institute for Empowerment and Development of Health Manpower was established to link and coordinate the previously separate centres in the development of an overall integrated strategic plan for health workforce development and a corresponding integrated information system. The *World health report 2006 – working for health* emphasized the critical role of government in developing sound policies and plans for human resources for health, and calls on governments to identify key issues and priorities for action. The Ministry of Health has expressed its commitment to this process and to improving the current situation.

Provision of health services

At the primary health care level, Indonesia is generally regarded as having relatively adequate levels of provision, with one public health centre for every 30 000 people on average. If sub-centres are included, there is one public facility per 10 000 people. However, these averages conceal large variations in geographic accessibility, with people in remote interior locations or small islands having particularly poor access. In addition to public facilities, private practices are operated by doctors, nurses and midwives, in many cases by the same personnel as are employed in public facilities. At the hospital level, Indonesia has low levels of bed provision at 0.6 beds per thousand population. Paradoxically, the utilization is also low, with bed occupancy rates in the vicinity of 50% in both public and private facilities. Low utilization is also observed in public health centres where it is common to have fewer patients per day than staff employed. It is widely assumed that the high level and unpredictability of user fees deter utilization. As in many countries, health services are disproportionately concentrated in urban areas and particularly in the larger cities, where the clientele with the greatest ability to pay resides.

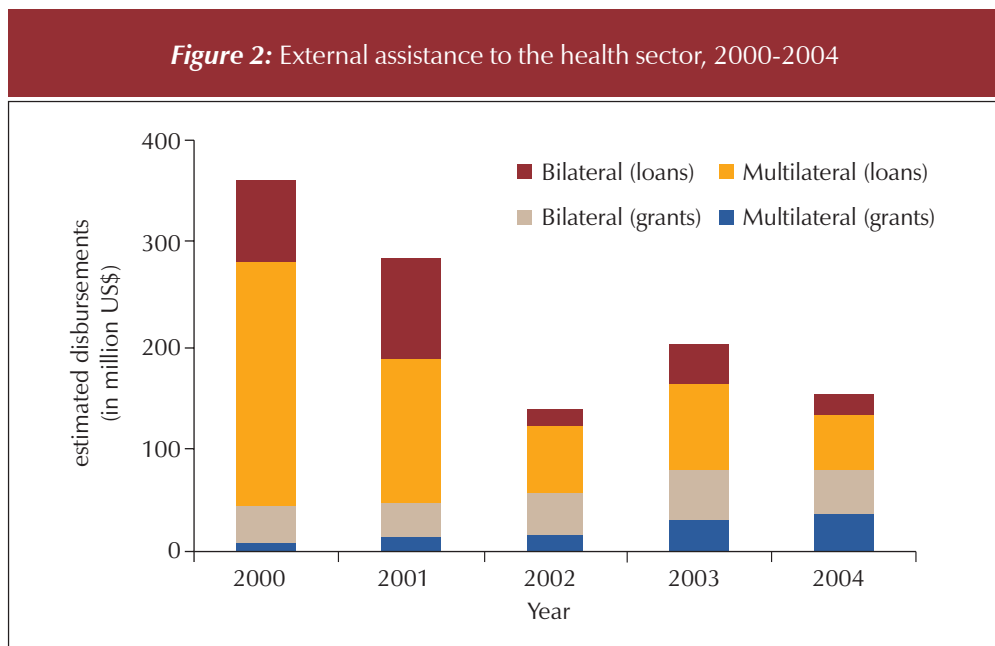
The private sector is increasingly important in the provision of health care in Indonesia, especially in big cities, with wide variations in quality of care. Furthermore, since there is no regulation of pricing or quality of service in place, users are vulnerable to unnecessary treatment and expenses. The role of nongovernmental organizations (NGOs) in Indonesia has been growing during the last two decades but the exact number of NGOs providing health care services remains unknown.

While medicines to treat the vast majority of tuberculosis, malaria and HIV/AIDS cases exist, drugs are not reaching everyone due to limited affordability and availability, as well as other factors. Despite the presence of a strong Drug Regulatory Authority, responsible for the registration of medicines as well as quality control and inspection, counterfeit drugs remain a big problem. The fight against counterfeit drugs is resource-intensive and requires substantial cooperation of other sectors. At the same time, the use of traditional medicines (such as *jamu*) is popular and widespread in Indonesia. Yet procedures for quality control of traditional medicines are limited in scope and difficult to implement, also because large numbers of small-scale manufacturers exist.

Development assistance and partnerships: aid flows, instruments and coordination

3.1 Overall trends of foreign aid in the health sector

During the last two decades, the international community has shown continuing interest in, and attention to, health development in Indonesia. International assistance in the health sector increased in the late 1980s, with fluctuating foreign assistance amounts through the mid-1990s. There was a sharp increase in foreign assistance at the onset of the economic crises in the late 1990s, but this assistance declined to pre-crisis levels by 2002. Figure 2 shows estimated external assistance to the health sector as a whole (not just to the government) for the period 2000 to 2004.



Source: WHO Indonesia, 2005.

3.2 Bilateral development agencies

The two largest bilateral grant providers are USAID and AusAID, together accounting for over half of all grants given and over four-fifths of bilateral grants given during the period 2000-2004. The larger part of bilateral grants goes to support maternal and child health (including nutrition and family planning) and communicable disease control, with smaller amounts supporting decentralization and health policy reform. Other

bilateral donors appear to address similar concerns. Bilateral donors in some cases bypass the central Government and disburse grants either directly to provincial or district governments, or to NGOs. Unlike multilateral loans, they did not experience the sharp slowdown in disbursement rates after the start of regional autonomy. However, many bilateral loans ended realization in 2000-2001, with only a few countries continuing to issue loans beyond this period. A major area addressed by bilateral loans is the procurement of medical equipment, but some provide support to specific projects (for example, HIV prevention measures, social health insurance, health information systems, community health and nutrition). During 2004, the Federal Republic of Germany and the Republic of Korea were the largest lenders to the health sector.

An analysis of loans currently proposed in the Ministry of Health shows that there is a growing interest in the upgrading or improvement of hospitals, with almost three-fourths of proposed loan funds in the Department of Health's bluebook being proposed for this category. Other areas that future loans may address include communicable diseases prevention and control and support for remote areas.

In 2005, substantial amounts of bilateral and multilateral funds were disbursed to address the triple challenges of tsunami-related problems, avian influenza and polio eradication. While the extent of these funds is not known at this time, they are expected to increase the share of health funds supported by external donors. It also reflects donors' sensitivity to help address health crises as they emerge. Many bilateral development partners and technical agencies meet at "partners in health" meetings, commonly along thematic lines, to offer a forum useful for consultation and coordination of activities. The support of such meetings for the new platform on health, and involvement in actual working groups, would help successful implementation of (and adequate funding for) the four national initiatives.

3.3 Development banks

In years past, support from the Asian Development Bank focused on ensuring access to health services through infrastructure investments, but the emphasis has shifted to building local management and clinical capacity, community empowerment and improving operational competence. The latest projects have supported the government's efforts to decentralize and modernize the planning and management of health services, emphasizing community participation in identifying needs, defining solutions, implementing programmes and monitoring implementation and outputs. The World Bank's focus has similarly been on increasing the capacity at local levels to manage the transition to regional autonomy, although some loans are still being provided in support of water and sanitation improvements.

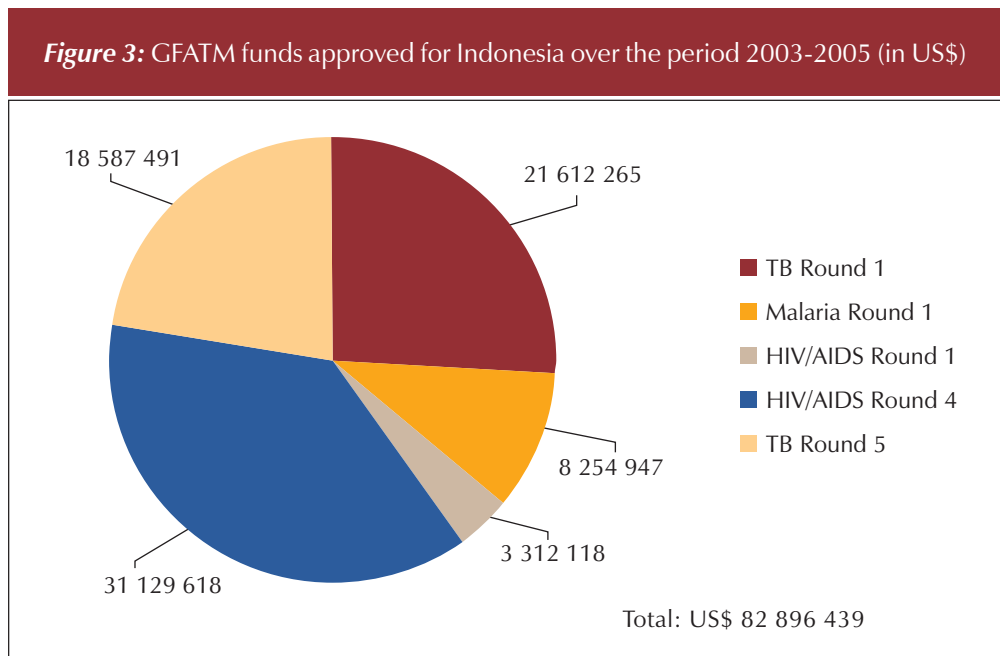
3.4 Global health initiatives as applied to Indonesia

In 2003, the Global Fund to fight Aids, tuberculosis and malaria (GFATM) and the Global alliance for vaccines and immunization (GAVI) started to disburse funds

earmarked for special programmes. In Indonesia the GFATM’s principal recipient is the Ministry of Health.

The Country Coordination Mechanism (CCM), responsible for formulating proposals to the GFATM and for overseeing the use of allocated funds, is made up of 39 members, of whom 16 are from the government sector; 16 from NGOs, private sector, academic institutions; and 7 from multilateral or bilateral organizations. The chair of the CCM is the Director-General, Communicable Disease Control, from the government sector; the first vice-chair is from the NGO constituency; and the second vice-chair from the multilateral-bilateral constituency (WHO). The CCM acts as the forum to forge partnerships between government and other actors from civil society. The CCM also coordinates its activities and shares information with other national bodies such as the National AIDS Commission, TB partners forum, and expert committee on tuberculosis, as well as the expert committee on malaria. To further improve the functioning of the CCM, three thematic working groups have been constituted for individual diseases. Meetings of the CCM are held quarterly.

WHO has displayed a leadership role in assisting the Ministry of Health in the preparation of GFATM proposals for rounds one to five. This led to a high success rate of grant approvals, resulting in substantial mobilization of external funding for the three diseases. WHO is also assisting the Ministry of Health in “making the money work” by actively participating in the CCM as well as providing intensified technical support to the TB and HIV programmes through the “intensified support and action” programmes, which use GFATM funds through WHO to support technical assistance. During the period 2003-2005, a substantial amount of grant money was mobilized under the GFATM mechanism (Figure 3).



Furthermore, during the period 2003-2005, GAVI funded a total of US\$ 25 million as well as “in kind” provisions, to help strengthen the areas of immunization services, injection safety and new vaccines.

3.5 WHO in the United Nations country team

There are currently 25 UN agencies, funds and programmes operating in Indonesia, of which 14 have country representative offices. WHO is a member of the UN country team and actively involved in the UN Development Assistance Framework (UNDAF), a common strategic framework for operational activities of the UN system at country level. The UNDAF provides a collective, coherent and integrated UN system response to national priorities and needs, including a draft poverty reduction strategy, MDGs progress report, a master plan for rehabilitation and reconstruction in the provinces of Nanggroe Aceh Darussalam (NAD) and North Sumatra and the Medium-term Development Plan 2004-2009. WHO is currently the lead agency for a number of UNDAF outputs related to improved health and nutrition. In order to achieve these outputs, WHO will help coordinate activities closely with other UN agencies working in health areas, in particular with United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), International Labour Organization (ILO) and Food and Agriculture Organization (FAO).

WHO, together with FAO, is taking the lead role in coordinating the UN approach to support national capacity to respond to avian influenza and pandemic preparedness, and to build capacity within the ministries of health and agriculture. The UN has also collectively been working together to support the national avian flu coordinating body, KOMNAS FBPI (Indonesia national committee for avian influenza control and pandemic influenza preparedness) through support to an interministry contingency planning workshop. To strengthen donor coordination, WHO, FAO and the World Bank co-chair *ad hoc* donor meetings on avian influenza. A capacity development project for the national avian influenza coordinating body is jointly being developed by the UN Resident Coordinator’s office, FAO and WHO, involving relevant UN agencies.

WHO is also an active member in the United Nations technical working group for disaster risk reduction which aims to improve UN coordination and facilitate support to the Government of Indonesia to manage risks from, and respond effectively to, disasters. The working group meets regularly to discuss issues of common concern and identify action points for implementation. It also aims to bring resources from the UN system and other donors together to be able to help government authorities in a coordinated manner.

3.6 Nongovernmental organizations

The importance of the NGOs’ role in Indonesia has been growing since the late 1970s. Initially, small national NGOs were formed to address socioeconomic conditions and

their concentrated activities on development programmes. A further expansion of NGOs occurred after the fall of president Soeharto's government in 1998. Increased channelling of external funds to NGOs resulted in a sharp increase in the number of NGOs. Several laws — both at national and village levels — regulate the presence and activities of NGOs in Indonesia.

There is little information on the number of NGOs providing health care services; the overall figures range from 8000 to over 13 000 officially registered NGOs. They can be divided into three broad categories: large, international (often quite influential) NGOs that have access to external funding and are often linked to their respective governments; small, local NGOs that are the more traditional grassroots NGOs working at community level; and NGOs connected with the Government of Indonesia and its respective ministries.

In response to the tsunami and subsequent earthquakes, a large number of NGOs arrived at Aceh and Nias. Many of them were involved in health activities and coordination of their activities became a major challenge for local health authorities. While most NGOs have since completed their programmes in the region, many are still present in the province of Nanggroe Aceh Darrussalam (NAD) providing long-term support to reconstruction and rehabilitation.

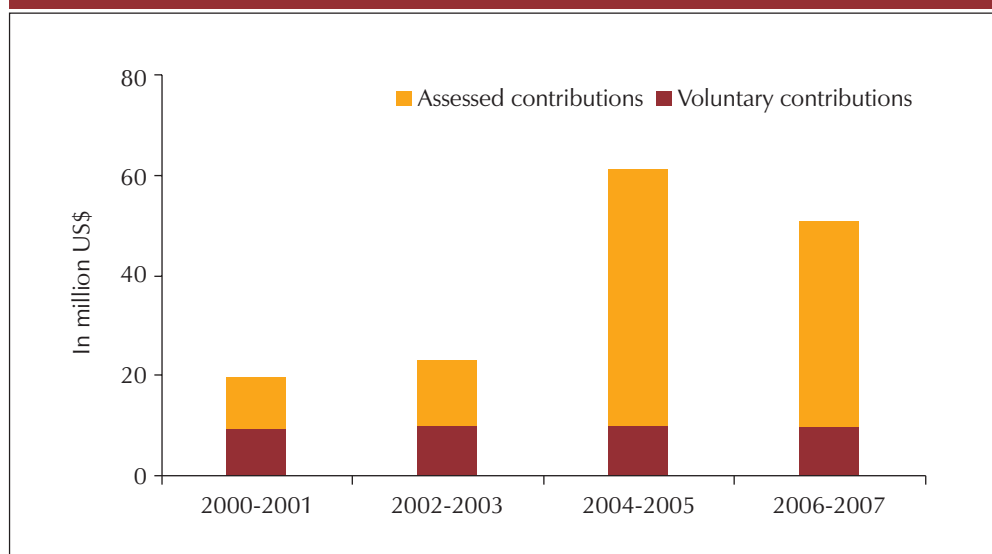
WHO collaborative country programmes in Indonesia

Indonesia joined the World Health Organization on 23 May 1950, just months after the country was liberated on 27 December 1949. WHO established a wide range of collaborative programmes with the government of Indonesia. The central goal of collaboration is the attainment of the highest level of health by the population. Since its inception, WHO has been playing an important role in national health development. Over the years, as health sector issues became ever more diverse, the scope of WHO support expanded to cover a large number of collaborative programmes and projects. Many initiatives funded routine activities. In 1996-1997, WHO introduced “umbrella” projects aimed towards better coordination of individual projects, with linkages and products to improve accountability and measurability.

During the 2000-2001 and 2002-2003 bienniums, WHO strengthened technical support to programmes through the establishment of fixed-term posts under two major areas, malaria and tuberculosis. Deployment of technical staff (for malaria and other vector-borne diseases on one hand and for tuberculosis on the other) assisted the country in its applications for GFATM funding. Considering motivational and performance factors among health care personnel, WHO enhanced technical support to health care services and developed training models that could be implemented in many parts of the country. The need for fixed-term staff was identified in the area of emergency preparedness and response in order to support national authorities in reducing the impact of crisis on the health of affected populations. In view of the vast size of the country, WHO explored different ways of delivering technical support efficiently and effectively. As a result, WHO established sub-offices in Banda Aceh (Aceh province), Kupang (NTT province) and Jayapura (Papua province).

In financial terms, WHO’s assessed contribution provided US\$ 9.892 million in the 2004-2005 biennium and allocated US\$ 10.127 million for the 2006-2007 biennium. Voluntary contribution funds channelled through WHO are considerable. During the 2004-2005 biennium, they totalled US\$ 51.1 million, *inter alia* as a result of the unprecedented tsunami on 26 December 2004. For the 2006-2007 biennium, a voluntary contribution total of US\$ 40.685 million was envisaged (as at January 2007). About 30% of assessed contributions are allocated for the WHO Indonesia country office. Figure 4 displays the development of assessed contribution country allocations and voluntary contributions from 2000 to date.

Figure 4: Assessed contribution allocations and voluntary contribution resources (in US\$), WHO Indonesia



The following table shows how assessed contributions in WHO country collaborative programmes were utilized during the 2004-2005 biennium.

Table 1: Distribution of WHO assessed contributions by areas of priority (WHO Country Cooperation Strategy for Indonesia, 2001-2005)

	Assessed contribution 2004-2005 (US\$)
Health policy and systems development	2 233 000
Prevention and control of communicable diseases	2 572 000
Noncommunicable diseases and health and environment	1 331 000
Health of women, children and adolescents	1 536 000
Emergency preparedness and response	477 000
Partnerships and coordination	1 023 000

WHO's financial support for the Ministry of Health is relatively small compared to the government's own budget for health, and compared to increasing support from development banks and other donor agencies. The strength of WHO is its strategic position as one of the main advisors to government and other partners in health in Indonesia, providing technical support and undertaking advocacy for key areas of health development in the country. The support of WHO through country

collaborative programmes is important both in health development situations and when disasters strike, as was the case in the wake of the unprecedented tsunami and subsequent quakes during 2005 and 2006.

WHO support can be divided into the following areas or functions:

- **Technical support for collaborative interventions:** Technical support is provided for public health priorities. These include, as mentioned, vector-borne diseases, tuberculosis and HIV-AIDS; polio and vaccine-preventable diseases; emerging infectious diseases (such as avian influenza; surveillance; nutrition; child, adolescent, reproductive health; and noncommunicable diseases. In these areas, adaptation and implementation of new programme guidelines and protocols is supported, as is area-specific facilitation. This requires extensive technical input.
- **Policy support for health system development:** There are key areas of the health system, including human resources for health, district health and decentralized planning, managing service delivery, health insurance and health financing issues. Much of WHO effort concentrates on background work – analysing current data and providing papers on these areas and on key policy issues. Where necessary, limited field trials, or training, are undertaken to pilot appropriate changes.
- **Support for donor-assisted initiatives to improve health:** The large amount of project funds provided by donors, often at peripheral levels, can have considerable impact on the health sector in Indonesia. This is especially true since many donor-assisted projects aim to concentrate on innovative programmes as they see it. WHO provides technical support to facilitate as appropriate.
- **Advocacy and technical support for emerging priorities in health:** This involves support for health initiatives expected to grow in importance in the coming years. Although more resources are currently being used to prevent and control communicable diseases, noncommunicable diseases are being given increasing attention. Health promotion in areas such as tobacco and health, and occupational diseases, requires WHO's support as well.
- **Technical support for emergency preparedness and response:** As Indonesia is prone to both natural and human-induced emergencies, technical support and assistance to government's donor coordination are important to mitigate the health impact of emergencies.
- **Other forms of technical support:** These include programme evaluations, assessments to identify current needs, short-term technical training and attending technical meetings.

The strengths of the WHO country office are:

- **Sound and impartial technical advice** in crucial technical areas. The Ministry of Health and all health partners perceive WHO as giving the best technical, non-partisan advice. WHO is widely seen as being the primary agency in health not only by the government, but also the donor community.
- **Frequent interactions with the Ministry of Health** at central level are essential. These include, but are not restricted to, counterparts in most directorates.
- **Partners' perception of WHO differs from their perception of donors.** Since the funds directly available to WHO are comparatively small and its role is quite different, WHO generally is not (and should not be) seen as a donor agency. This may help to avoid the possible criticisms associated with aid that is donor-driven.
- **Technical back-up** from global and regional levels of WHO (including mechanisms exemplified by the global outbreak alert and response system) is an important advantage. It enables the country office to obtain technical assistance, sometimes at short notice.
- **Involvement in health system** work, social health insurance, health financing and decentralization. This has been a special feature of WHO's work in Indonesia. For the last five years, WHO has been working closely with the Ministry of Health in the area of health systems, providing technical advice and expertise.
- **Collaboration with NGOs and the donor community.** While there is no formal mechanism for collaboration with NGOs, there is a good working relationship and cooperation between NGOs working in the health sector and the WHO country office.
- **Collaboration with sectors outside health**, for example with the Ministry for the Role of Women, Ministry of Agriculture, Ministry of Education, or the Family Planning Board, is vital to achieve health benefits.
- **Technical support at provincial and district levels** is provided through placement of national staff under key communicable disease programmes (tuberculosis, HIV-AIDS, polio). In addition, WHO maintains its presence at the sub-office level in Banda Aceh, Kupang and Jayapura. This is especially useful within the framework of the decentralization process.

Some constraints of the WHO country office are:

- Limited funds for programme implementation, except for tuberculosis and HIV-AIDS, polio and surveillance. Some small amounts need to be available

in areas where other funding is not available. The potential importance of seed money, which can be catalytic, should not be overlooked.

- Many technical programmes are managed rather vertically from global and regional levels of the Organization. This can lead to serious distortion, or even displacement, of actual needs and priorities.
- WHO staff and funds are often linked to, or are seen as 'belonging to' specific programmes or units within the Ministry of Health, which may constrain collaboration with other partners.
- It can be difficult to *sustain* appropriate staff support at country level, for technical, financial, personnel or administrative reasons.

Issues that may be considered in working with the Ministry of Health include difficulties in implementing new and innovative approaches in a bureaucratic system and a certain degree of reservation regarding inter-unit cooperation. Intersectoral collaboration in areas such as tobacco and health, HIV-AIDS, health insurance or adolescent health is difficult, also due to the involvement of other influential ministries. This is the case also for other health-related programmes, such as child health or making pregnancy safer.

WHO policy framework: global and regional directions

5.1 Global policy framework

The General Programme of Work (GPW) is a fundamental health policy document for WHO and Member countries. The Eleventh GPW sets out the direction for international public health for the period 2006-2015. The document notes that there have been substantial improvements in health over the last 50 years. However, significant challenges remain, as described in the following four gaps:

- **Gaps in social justice:** Clearly poverty is a key factor in access to quality health services, maintaining the vicious cycle of poor health and poverty. Discrimination through ethnicity or gender reduces access to services. The special issues of women's health are often not adequately addressed. In some countries, life expectancy of the poor is about 20 years lower than that of more privileged members of society.
- **Gaps in responsibility:** Solving health problems is no longer merely a responsibility of those working in health, but requires action by those outside the health sector. International conflicts and national crises often lead to disruption of social services, including health care. Globalization and decisions made regarding international trade have direct impacts on health, especially in regard to the movement of health professionals and in the pharmaceuticals sector. Ministries of health everywhere often find it very difficult to influence important causes of ill-health outside the health sector.
- **Gaps in implementation:** Technologies exist to implement cost-effective interventions to improve health. However, these are frequently not implemented due to lack of funds, human resources or an effective health system. Those resources available may often be allocated to high-cost curative services and favour urban areas, while relatively inexpensive and effective interventions in rural and remote areas are neglected.
- **Gaps in (access to) knowledge:** Advances in science and technology have improved effectiveness and efficiency of health services prevention of disease and promotion of health, and curative and rehabilitative interventions. However, information about these advances is not always available in countries. Furthermore, shortages of information about health conditions,

needs and programmes make it difficult to formulate and manage effective health policies and interventions. Operational research (aimed at those most in need) is often neglected, further reducing the efficiency of service delivery in key areas.

In order to reduce these gaps over the coming 10 years, the Eleventh GPW outlines a global health agenda consisting of seven priority areas:

- (i) Investing in health to reduce poverty;
- (ii) building individual and global health security;
- (iii) promoting universal coverage, gender equality and health-related human rights;
- (iv) tackling the determinants of health;
- (v) strengthening health systems and ensuring equitable access;
- (vi) harnessing knowledge, science and technology, and
- (vii) strengthening governance, leadership and accountability.

This global health agenda is meant for all those working in health development. WHO will contribute to this agenda by concentrating on its core functions, as shown in Box 1, based on the comparative advantages of the Organization.

Box 1: WHO's core functions

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- setting norms and standards, and promoting and monitoring their implementation;
- articulating ethical and evidence-based policy options;
- providing technical support, catalysing change, and building sustainable institutional capacity; and
- monitoring the health situation and assessing health trends.

In accordance with the global health agenda and WHO's core functions, the Organization has set the following priorities:

- (i) Providing support to countries in moving to universal coverage with effective public health interventions;
- (ii) Strengthening global health security;

- (iii) generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- (iv) increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
- (v) strengthening WHO's leadership at global and regional levels and supporting the work of governments at country level.

WHO will implement these priorities through its global Medium-term Strategic Plan (2008-2013) and the biennial budgets of the Organization. WHO's Director-General places a major focus of work for the Organization at country level. Regional offices and headquarters have been directed to emphasize support for country work and implement these priorities in Member countries, especially involving people in greatest need.

5.2 Regional policy framework

The WHO South-East Asia (SEA) Region has the second highest population of the six WHO regions and has the greatest burden of disease. While there has been great economic development in recent years, the problems of poverty and poor health remain. Many countries have faced health emergencies in the last decade and the threat of disease outbreaks is ever-present. At the same time, NCDs have become an increasingly important cause of morbidity and mortality for countries of the SEA Region. Therefore, the global policy framework of WHO is appropriate for countries of the Region, with special attention to strengthening the capacity of Member countries to implement priority public health interventions.

The WHO SEA Region has traditionally placed strong emphasis on its work in and with Member countries. Of the budget provided to the Region, 75% is allocated for countries, the highest of any WHO region. The 11 countries have strong WHO country offices active in health development initiatives. The Regional Director of the SEA Region recently increased the delegation of authority to country offices to help facilitate implementation. Regional and country levels of WHO share accountability for their work. At the same time, the Regional Director has emphasized that the Regional Office should give highest priority to supporting work in countries. The WHO country cooperation strategy is a tool to focus WHO support for countries to maximize health benefits nationally and internationally.

Strategic agenda for WHO in Indonesia

The overall goal of the World Health Organization in Indonesia continues to be to improve the health of the peoples of Indonesia by supporting health development and an effective response to urgent needs, advocating health promoting policies, raising awareness of neglected public health priorities and providing technical leadership in collaboration with the government, donor partners and other actors in health. WHO will strive to align its activities with the national agenda and work towards a more equitable and efficient health system that recognizes health in Indonesia as a shared resource and a shared responsibility. These goals will only be achieved through an optimal mix of partnerships in health. In addition, WHO will also help the country share its experiences with other countries, regionally as well as globally, by offering platforms and mechanisms for exchange.

As set out above, Indonesia is engaged in the process of ensuring an effective decentralization and functioning of the health system while at the same time responding to urgent health needs brought about by natural disasters and emerging and re-emerging communicable and noncommunicable diseases. Against this background, a key objective of WHO's strategy will be to work with other development partners to support the government in narrowing the gap between policy intentions and policy implementation, and in supporting the new platform for health to secure a more equitable, efficient and effective health system, including a responsive and fair financing of a decentralized health system.

While initiatives to improve the health system affect all activities in WHO during this period, selected technical areas deserve high priority from the present through 2011. In the light of country needs, government policies, activities of other development partners and WHO's own objectives, the WHO CCS for Indonesia has identified six priority areas:

1. Health policy and system development;
2. prevention and control of communicable diseases;
3. health of women, children and adolescents;
4. noncommunicable diseases, mental health, health and environment;
5. emergency preparedness and response; and
6. partnerships, coordination and WHO's presence in countries.

Strategic directions

Six strategic directions have been identified in relation to the priority areas listed above

Strategic directions

1. Support national efforts to promote policies and strengthen the health system to improve access to quality health services.
2. Provide technical and management support to help sustain and strengthen key programmes to prevent and control communicable diseases.
3. Promote policies and strengthen programmes to improve child, adolescent and reproductive health.
4. Promote public health approaches to prevention and control of noncommunicable diseases, mental health and environmental health.
5. Strengthen emergency preparedness and response.
6. Promote partnerships, coordination and WHO's presence in countries.

Health policy and system development

Health policy and system development is the area where WHO envisages concentrating a substantial part of its effort through 2011. Decentralization and subsequent changes in the health system have had an extensive impact on all aspects of service delivery. There is a clear need to help shape and develop responses to health sector elements in this field, from district health systems to social health insurance. Support to defining roles and functions of the health system at different levels of government may involve human resources for health, health sector performance, increasing and redirecting health sector financing including further development of social health insurance, and determining how health institutions could develop to foster effective community participation. Managerial aspects of service delivery and institutional arrangements are likely to feature in the activities as well.

Strategic directions

1. Support national efforts to promote policies and strengthen the health system to improve access to quality health services.

Strategic actions

- 1.1 Analyse health finance information and advocate supportive policies, including health insurance.
- 1.2 Develop and promote innovations to improve the management of the health system, especially through:

- Defining the appropriate roles, responsibilities and functions in a decentralized health system;
 - improving the regulation of public and private provision of health services;
 - improving planning, especially at the district level;
 - improving the management of essential drugs and equipment; and
 - promoting operational research to develop and evaluate programmes and system innovations.
- 1.3 Strengthen and institutionalize information systems with emphasis on the district level, including better monitoring and use of data.
- 1.4 Strengthen the management capacity of the health workforce, especially through:
- Promoting the use of appropriate standards and protocols;
 - improving the licensing and regulation of health workers in both public and private sectors;
 - strengthening the management of health facilities and clinical governance;
 - improving incentives and motivating health workers, especially in remote and underserved areas, as well as for key public health functions; and
 - strengthening the pre- and in-service training, emphasizing public health and service delivery.

Prevention and control of communicable diseases

During 2007-2011, WHO will continue to support the Ministry of Health in design and implementation of effective communicable-disease control programmes to reduce excess mortality, morbidity and disability, especially in populations with limited access to health services. In situations where emerging and re-emerging communicable diseases place immense strain on health systems, WHO will make concerted efforts to respond rapidly to urgent needs and to strengthen the development of effective disease control programmes.

Strategic directions

2. Provide technical and management support to help sustain and strengthen key programmes to prevent and control communicable diseases.

Strategic actions

- 2.1 Continue providing technical support for the implementation of communicable disease programmes;

- 2.2 strengthen the management of communicable disease programmes including the development of proposals, resource mobilization, monitoring and evaluation;
- 2.3 strengthen the expanded programme of immunizations;
- 2.4 strengthen health laboratories and blood safety; and
- 2.5 strengthen surveillance, response to and preparedness for disease outbreaks and pandemics, especially in the context of the International Health Regulations (IHR-2005).

Health of women, children and adolescents

Through technical support to the new directorates of maternal and child health, nutrition and others, WHO aims to promote implementation of evidence-based interventions shown to impact positively on mortality, morbidity and development. WHO will not only emphasize improved access to services, but also quality improvement of comprehensive and integrated health services for women, children and adolescents. Those services should be comprehensive including prevention, promotion and care. To help reach those in need, WHO will focus to improve health managers' understanding of gender and maternal, adolescent and child rights issues in order to fully integrate these perspectives into policies, strategies and implementation at local level.

Nutrition, a critical common factor in both mortality and morbidity, remains a key public health problem. To help address this priority, WHO supports the integration of nutrition into related programmes. To be able to maximize the scale and impact of nutrition interventions, sufficient resources should be allocated nationally and internationally. All stakeholders need to support implementation of the national, intersectoral plan of action for nutrition, and work in close collaboration to do so.

Strategic directions

- 3. Promote policies and strengthen programmes to improve child, adolescent and reproductive health.

Strategic actions

- 3.1 Provide technical support and promote the scaling-up of priority interventions;
- 3.2 promote increased access for all (in particular the most vulnerable), to good quality preventive and curative services by public and private providers;
- 3.3 advocate strengthening of national capacity to integrate gender equity and a human rights approach into policies and programmes;
- 3.4 support coordination of stakeholders and resource mobilization to facilitate implementation research (or essential national health research); and

- 3.5 support implementation of nutrition interventions – and their integration – in all related programmes.

Noncommunicable diseases, mental health, and health and environment

This strategic area concentrates on integrating health promotion and disease prevention activities into key health programmes. This includes encouraging government to attach more importance to the risks posed by tobacco, unhealthy diets, lack of physical activity, unsafe water, inadequate sanitation, lead in petrol, traffic congestion and the use of solid fuels for cooking. Extra efforts are envisaged to help integrate Indonesia with global efforts to control tobacco. WHO endeavours to play a more strategic role in health and environment by supporting development of policies and priorities for a healthy environment, responding to climate change.

Strategic directions

4. Promote public health approaches to prevention and control of noncommunicable diseases, mental health and environmental health.

Strategic actions

- 4.1 Advocate the importance of addressing the increasing national burden of noncommunicable diseases and the key role of prevention;
- 4.2 support monitoring of the prevalence of noncommunicable diseases and related risk factors;
- 4.3 support the development and implementation of national, intersectoral strategies for improved diet and physical activity;
- 4.4 support the development and implementation of national strategies to address disabilities, especially blindness;
- 4.5 strengthen the development and implementation of community-based mental health programmes;
- 4.6 support adherence to, and implementation of, WHO's Framework Convention for Tobacco Control; and
- 4.7 promote the environmental aspects of health, as climate change rapidly emerges as a defining issue of our time.

Emergency preparedness and response

In several provinces of Indonesia, people and government are repeatedly challenged by natural disasters with serious consequences for the health of those affected. Building on experience gained during the emergency response to tsunami and subsequent quakes, WHO continues to support the Ministry of Health and other relevant national authorities to further develop national capacity for emergency preparedness and response to public health needs.



Strategic directions

5. Strengthen emergency preparedness and response.

Strategic actions

- 5.1 Encourage adoption of international best practices and minimum standards in emergency management;
- 5.2 support the development of emergency management capacity in government ministries;
- 5.3 emphasize emergency mitigation and preparedness, including better hazard and vulnerability assessments;
- 5.4 mobilize voluntary contribution resources for emergency relief activities in support of disaster-affected populations; and
- 5.5 promote the prevention of, and response to, injuries and accidents.

Partnerships, coordination and WHO's presence in countries

WHO's presence in countries is essential to help deliver large and complex collaborative programmes in support of national and international health development. WHO will be alert to adjusting its own modalities of support to changing needs and priorities. It continues to advocate for increased investment in health and aims to facilitate technical assistance for health. The Organization can do so by acting as a broker and by exercising influence with partners. It aims to facilitate information-sharing among a range of health actors, including technical updates and situation reports.

Strategic directions

6. Promote partnerships, coordination and WHO's presence in countries.

Strategic actions

- 6.1 Advocate for WHO policies, roles and functions to government, the international community and the United Nations system in Indonesia;
- 6.2 support the Ministry of Health in coordinating health partners and in fostering intersectoral collaboration;
- 6.3 support investment in health in Indonesia, from national and international sources;
- 6.4 strengthen partnerships among health actors as appropriate, for example NGOs, UN and bilateral agencies, universities and development banks;
- 6.5 facilitate exchange of information about local-level health initiatives to influence national policies and programmes; and
- 6.6 improve knowledge management in WHO, including the dissemination of relevant public health information.

Implementing the strategic agenda: implications for the WHO Secretariat

To achieve the strategic objectives outlined in the preceding section for each priority area, the WHO country office in Indonesia must be equipped with adequate resources and support. The concerted support of WHO as a whole will be needed to implement the CCS effectively. It will entail changes both in the country office and in the timely and appropriate support to be provided by the WHO Regional Office, WHO headquarters and WHO elsewhere in the world.

The staffing pattern of the WHO country office, during 2007-2011, intends to reflect the specializations outlined for the different strategic areas below, with balanced investments from both assessed contribution and voluntary contribution resources to do so.

7.1 WHO country office

Priority area 1 – Health policy and system development: With the continued focus on strengthening health systems during 2007-2011, technical and managerial expertise will be essential, especially in the areas of district health systems and decentralization, human resources for health, health financing and social health insurance.

Priority area 2 – Prevention and control of communicable diseases: As prevention and control of communicable diseases encompass both endemic and emerging infectious diseases, and both are clearly relevant in the country context, the assistance of experts is required who have experienced comparable situations elsewhere. It is important for such experts to visit the country from time to time to assess the situation, to help specify and address technical needs. In addition, identification and sharing of relevant reports and technical papers can provide necessary inputs for local technical work. This will require active attention from WHO resources outside the country. Significantly, more resources should be placed towards surveillance of, and response to, emerging communicable diseases (including but not confined to avian influenza), a key element of the strategic agenda. Furthermore, prevention and control of tuberculosis, malaria, HIV-AIDS, and other priorities such as eradication of poliomyelitis and the expanded programme of immunization generally, would clearly benefit from continued support as well as from regular international reviews. Periodic reviews may generate timely inputs to relevant programmes and help render available

resources and local approaches more effective. Materials and guidelines developed in other parts of WHO can provide crucial support for local implementation. In some cases, special materials and procedures can be developed with international assistance. Support towards prevention and control of dengue haemorrhagic fever, Japanese encephalitis, rabies, and towards elimination of leprosy and lymphatic filariasis as public health problems, would also need to continue, with appropriate adjustments.

Priority area 3 – Health of women, children and adolescents: Relevant input from development partners can enhance the role that WHO plays as provider of technical support. Additional resources are likely to be needed to support implementation of the national plan of action for nutrition. Adolescent health clearly deserves greater attention. Developing appropriate tools and guidelines, and implementing those that already exist, are additional areas where WHO support can make a difference – not least in the context of women’s health and human rights approaches, and mainstreaming these in other programmes.

Priority area 4 – Noncommunicable diseases, mental health and the environment: This area would benefit from special assessments to determine local strategies and priorities in line with the available global best practices. Extra effort needs to be made to put the neglected public health problems such as noncommunicable diseases, mental health, injury and tobacco use higher on Indonesia’s health agenda. Periodic reviews also need to consider the extensive work of other development partners who may have a much larger impact and role than WHO. It is essential to identify where WHO can make a key contribution in these areas and play a proactive role in integrating with other partners to maximize the health benefit.

Priority area 5 – Emergency preparedness and response: Indonesia is the world’s largest archipelago. Geomorphologically, it sits on the Pacific “ring of fire”, exposed to tectonic and volcanic instability. Therefore, additional resources and long-term staff presence are required to help shift WHO’s focus from reacting to disasters towards supporting national authorities to improve preparedness and response. Strengthening capacity is key: WHO will support the establishment of national emergency preparedness and response hubs which in turn help mobilize emergency services in the decentralized system. WHO-supported emergency situation reports would aim to complement information management in emergencies.

Priority area 6 – Partnerships, coordination and WHO’s country presence: Sufficient technical and support personnel are the key WHO resource to assist in the delivery of collaborative programmes and in the mobilization of additional resources. Furthermore, coordination and partnerships require a constant presence, and demand more personnel and other resources to be effective with United Nations and other partners. A review of operations and staff functions in the country office could help optimize utilization of existing or expected resources. Also, information management and media relations are crucial to address these functions.

7.2 WHO/SEARO and WHO/HQ

It is anticipated that the Regional Office will provide technical, administrative and managerial support for the implementation of multicountry activities. Solid technical and administrative support and back-up would be expected during implementation of collaborative country programmes. Headquarters is expected to assist especially in the areas of communicable disease surveillance and response, health systems development and health financing, noncommunicable diseases and emergency preparedness and response.

7.3 Coordination within WHO

Coordination between various levels of the Organization is important to maximize support for its country cooperation strategy. Mechanisms should be developed to ensure that regular information-sharing in specific technical areas takes place, that resource mobilization is coordinated and followed up, and that joint planning for biennial workplans is strengthened. This will require an interactive process involving all levels of the Organization during planning and implementation. It would help to commence interaction early on in the planning process, to help ensure that country needs are reflected in the global and regional objectives of WHO.

7.4 Financing the WHO country cooperation strategy

Assisting the government in the implementation of national health plans and priorities will benefit from practical experiences and expertise from other countries. Indonesia, in turn, may have lessons for other countries. Additional funding will be required for increased staff and consultants – but with a large and health-conscious community of development partners in Indonesia, WHO believes that this country cooperation strategy will provide the basis for mobilizing further resources both for the government and for WHO's own programmes.

However, while the outlook for increased voluntary contribution resources is likely to be good, there are implications for the country strategy. Appealing for money means that more technical resources will be needed to hold discussions with possible funding agencies and to prepare proposals for donors. In addition, donors expect accountability if they are providing specific funds for various projects. Dependence on voluntary contribution support will always involve the fine line between technical support as opposed to actual implementation. The country office must be able to limit its support for operational activities, as these are likely to require extensive staff and administrative inputs. Finally, the greater use of voluntary contribution funding must consider integration of activities into WHO collaborative workplans as opposed to a "project approach", as well as the smooth execution of administrative procedures. Delegation of authority

within the Region has helped in responding to needs, despite the increased workload. At the same time, the country office requires additional technical and administrative support from the Regional Office and headquarters in order to ensure the timely implementation of donor-funded projects. In the administrative areas, special support is needed for procurement and recruitment of necessary technical and administrative staff. WHO will ensure the efficient coordination among all levels of the Organization to ensure effective support for country office implementation.

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Abbreviations and acronyms

ADB	Asian Development Bank
AusAid	Australian Agency for International Development
BPS	<i>Biro Pusat Statistik</i> (Central Bureau of Statistics, Indonesia)
CIDA	Canadian International Development Agency
CCM	country coordination mechanism (of global fund grants)
CCS	WHO country cooperation strategy
CDC	communicable diseases control
CSR	communicable disease surveillance and response
DepKes RI	<i>Departemen Kesehatan, Republik Indonesia</i> (Ministry of Health, Indonesia)
<i>desa siaga</i>	village preparedness
DANIDA	Danish International Development Agency
DFID	Department for International Development (of the United Kingdom)
EHA	Emergency and humanitarian action
EPI	Expanded Programme of Immunization
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FINNIDA	Finnish International Development Agency
GAM	<i>Gerakan Aceh Merdeka</i> (Free Aceh Movement)
GAVI	Global Alliance for Vaccines And Immunization
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GPW	Global Programme of Work (of WHO and its Member States)
GTZ	<i>Gesellschaft fuer technische Zusammenarbeit</i> (German technical cooperation)
ILO	International Labour Organization
IMAI	integrated management of adult illness
IMCI	integrated management of childhood illness
JICA	Japanese International Cooperation Agency

KfW	<i>Kreditanstalt fuer Wiederaufbau</i> (German financial cooperation)
KOICA	Korean International Cooperation Agency
MDGs	UN Millennium Development Goals
MoH	Ministry of Health (Indonesia)
MTSP	Medium-term Strategic Plan 2008-2013 (of WHO)
NAD	Nanggroe Aceh Darrussalam (province)
NGOs	nongovernmental organizations
NORAD	Norwegian Development Cooperation
NPO	National Professional Officer
RI	<i>Republik Indonesia</i> (Republic of Indonesia)
RB	regular budget
SARS	severe acute respiratory syndrome
SIDA	Swedish International Development Agency
SEARO	Regional Office for South-East Asia
TB	tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

This Country Cooperation Strategy (CCS) Indonesia is a medium-term vision of the World Health Organization's efforts to support health development in Indonesia in the next five years. It is based on analysis of the current health situation in the country, health policies and programmes of the Ministry of Health, the work of other health development partners in Indonesia and the previous work of WHO in the country. The CCS was developed through close consultations with the Ministry of Health and key health development partners in Indonesia. The strategic agenda outlined in the document presents the strategic directions and actions that WHO can most effectively carry out to support health development. This strategic agenda will be used to guide the work of WHO in Indonesia at all levels of the Organization.

The six strategic directions that are outlined here are to: (1) Support national efforts to promote policies and strengthen the health system to improve access to quality health services; (2) provide technical and management support to help sustain and strengthen key programmes to prevent and control communicable diseases; (3) promote policies and strengthen programmes to improve child, adolescent and reproductive health; (4) promote public health approaches to prevention and control of noncommunicable diseases, mental health and environmental health; (5) strengthen emergency preparedness and response; and (6) promote partnerships, coordination and WHO's presence in the country. The final section of the CCS discusses the requirements for WHO to implement this strategic agenda in Indonesia. These include key constraints, issues requiring special attention, support needed from the WHO Regional Office and headquarters and financing requirements.



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