



WHO country cooperation strategy for Indonesia 2006-2011

2007

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Abbreviations

1. Introduction

WHO introduced the formulation of WHO county 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 2000-2005. In line with WHO global and regional policy frameworks and following an assessment of WHO 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 2006-2011. 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. of 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 country cooperation strategy for Indonesia will serve as a guiding document in the development of the Organization's collaborative country workplans with the national health authorities.

The period 2001-2005 witnessed significant changes in the health sector in Indonesia. The political and socio-economic 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* vision adopted by the government and the increasing importance paid to the UN millennium development goals (MDGs) and its 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 biennia, 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 benefit from such resources to address burning issues of the health system, while focusing on the poor and marginalized sections of society. The country faces additional challenges, exemplified by the emergence of 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 exposed the need to re-visit the original country cooperation strategy for Indonesia, to maximize WHO collaboration and contribution. In March 2004, a 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 country cooperation strategy be continued and that they form the starting point to bring the country cooperation strategy 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 country cooperation strategy for Indonesia 2006-2011, in a series of consultations with a wide range of stakeholders from Ministry of Health, Indonesia, civil society and other bilateral, multilateral and nongovernmental partners in health in the country. Numerous comments and suggestions have been taken into account subsequently in producing the present corporate document, WHO's country cooperation strategy for Indonesia 2006-2011.

2. 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 percent 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 which extends from May to October, and the rainy season from 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. Altogether, in 2006, there are 440 districts and 91 municipalities in Indonesia. Additional administrative units are sub-districts and villages. In 2006, there were 5,263 sub-districts and 62,806 villages in Indonesia (Ministry of Home Affairs, Indonesia).

Indonesia proclaimed independence from several centuries of colonial rule on 17 August 1945. Since then, the country experienced several profound political developments. Indonesia's founder president Soekarno was succeeded by president Suharto in 1966. A *new order government* was established, oriented toward directed overall development. A

period of uninterrupted economic growth was experienced from 1968 to 1996, when per capita income increased sharply from about US \$50 to US \$385 in 1986 and to US \$1,124 in 1996, as the national economy expanded at an annual average rate of nearly 5%. This experience was abruptly reversed by the economic crisis affecting Southeast Asia in 1997.

In 1997 and 1998, Indonesia went through its worst economic crisis since independence. Economic growth reversed, to negative 13 percent (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. Abdurrahman Wahid was president from 1999-2001. Megawati Soekarnoputri, daughter of founder president Soekarno, was president from 2001-2004. Historic presidential elections took place in October 2004, direct for the first time, when Indonesia's current president, Susilo Bambang Yudhoyono, came to office. Since 2000, the economy has resumed annual growth at rates of between 4 and 6 percent. Under the current dispensation, health and education have received more attention, as reflected in the increasing national budget for these sectors.

UN millennium development goals

In September 2000, at the 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 which sectors to develop. 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 have been 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

Health Law number 23, enacted in 1992, provided a 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 healthy-oriented national development
- to maintain and enhance individual, family, and public health, along with improving the environment
- to maintain and enhance quality, equitable and affordable health services
- to promote public self-reliance in achieving good health.

During 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 by the government to health. 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 process of, developing the policy platform.

As a follow up during 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-orientated, rapid and appropriate response, team work, high integrity, and transparency and accountability. The four pillars or priorities, which form the basis of the new health approach, are:

1. **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.
2. **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.
3. **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.
4. **Increase of health financing** through the 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 socio economic indicators. Life expectancy at birth reached 64 years for males and 67 years for females in 1996 and the infant mortality rate gradually declined from 142 per 1,000 in 1968 to 50 per 1,000 in 1998. The proportion of population living in poverty dropped dramatically from 60% in 1970 to an estimated 11-13% in 1996 and literacy rate for those aged 10 years or more was 89% in 1997. However, these achievements received a set back 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. In addition, by 2005, life expectancy for males was estimated at 67 and for females at 71 years of age.

Indicators show that the **health situation of mothers and children** 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 45 and 35 deaths per 1,000 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 Indonesia has the highest **maternal mortality ratio** (307/100,000 live births) in the Southeast Asian region (IDHS 2003). The lifetime risk of a mother dying of causes related to childbirth is estimated to be 1 in 65—compared with 1 in 1,100 in Thailand (WHO 2002). In Indonesia, 58% of deliveries are estimated to take place at home, of those 33% are in urban and 77% 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 of concern in the cities, while in rural areas the majority of women in need have no access to emergency services. Ministry of Health has made advances in addressing maternal mortality by focusing on three main areas outlined in the *national 2001-2010 making pregnancy safer strategy*, i.e.:

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

There has been a decline in **fertility** in Indonesia from 3.0 children per woman in 1988-1991 to 2.6 children per woman in 2000-2002. 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.

Communicable diseases continue to be a 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 GTB 2006). Malaria remains a major vector borne disease in large parts of Indonesia and large scale outbreaks of dengue haemorrhagic fever are reported every year. Although leprosy has been eliminated at national level, Indonesia ranks as number 3 in terms of global burden. Indonesia has overtaken Viet Nam in the number of deaths from avian influenza, with case fatality rates in 2006 nearing 75%. 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 in Indonesia. 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 a 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, 4,700 people living with AIDS (66%) are on, or have received, ART treatment (CDC, Ministry of Health, Indonesia).

An epidemiological transition towards **noncommunicable diseases (NCDs)** is becoming a major problem and 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. Noncommunicable diseases are heading to become a major public health problem, requiring sustained prevention and control of the risk factors involved. WHO's global strategy in prevention and control of noncommunicable diseases has been adopted by the country. The major challenge ahead will be to implement the strategy and to develop multisectoral public policies in support of the strategy.

Mental health has been long 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 on the mental health of affected populations. It soon became clear that a large number of people were suffering from mental health 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. Ministry of Health, Indonesia, 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, leaded gasoline in cities and major forest fires throughout Indonesia negatively impact 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, has 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 man made disasters, resulting in deaths and disabilities for many people. It is naturally exceedingly difficult for the country's health care system (as indeed 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 *inter alia* 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 system, human resources for health and service provision have been affected. Under decentralization, responsibility for health care provision is largely in the hands of regional governments.

Health financing

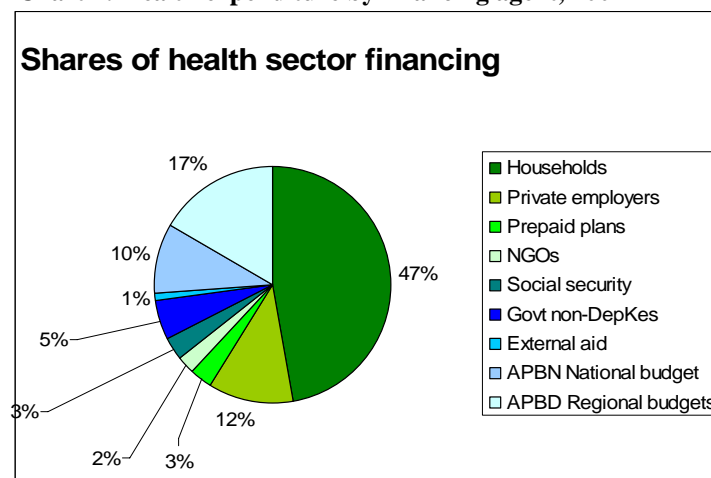
If compared with Malaysia and Thailand, Indonesia spends relatively little on health services. Estimated total expenditure on health (*per capita*, in 2002) was \$26 in Indonesia compared with \$149 in Malaysia and \$90 in Thailand (all figures in current US dollars at the then prevailing exchange rate, *Indonesia public health expenditure review*, 2004). Within that, public sector spending on health (*per capita*, in 2002) was estimated at \$9 in Indonesia, \$80 in Malaysia and \$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 give 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 the chart below, around 36% of total expenditure is undertaken 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

total expenditure. Privately provided services 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 can be observed. Distribution of household expenditures is even more skewed in favour of upper income groups than the distribution of incomes itself. This reflects low utilisation of health services by poor people and low use of public hospitals. Coverage of insurance, or direct employer paid benefits, is confined to a minority of formal sector employees. Public budgets are distributed inequitably between geographic areas, while benefit incidence analysis showed that implicit subsidies were captured largely by higher income groups. Since 2005, a new non-contributory scheme has been designed to provide state subsidised health insurance for poor households, using the civil servants' scheme as insurance carrier. This is an important positive initiative, which may begin to address some of the above. 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.

Chart 1: Health expenditure by financing agent, 2002



Source: adapted from Indonesia national health accounts, 2006

A larger proportion of budgeted public expenditure now appears in district budgets, up from 10% prior to decentralisation to 50%. In part, this merely reflects the transfer of responsibility for meeting civil servant salaries 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 deconcentration 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 deconcentration component and the new commitment to provide insurance coverage for the poor. In 2002, as depicted by the above chart, Indonesia's health sector was not heavily dependent on external flows, accounting for less than 2% of total expenditure. They constituted a larger 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 flows, which had risen markedly during the

economic crisis 1997-2000 before declining. They rose again in subsequent years, with the inception of new sources of funding, such as GAVI and GFATM.

Health information system

Decentralization resulted in a partial breakdown of health information systems and led to an unclear division of reporting responsibilities. As a result, no comprehensive data exist that cover the entire nation. The disruption of the information flow makes it difficult to develop strategies and monitor health programmes in provinces and districts. Exceptions do exist in some vertical programmes (tuberculosis, malaria or HIV-AIDS) where central government retains responsibility as 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 the maldistribution and reportedly low productivity of health workers. Under decentralization it has become harder for civil servants to be re-deployed 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. Ministry of Health, Indonesia, has expressed its commitment to this process and to improving the current situation.

Provision of health services

At 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 or small island locations 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, utilisation is also low, with bed occupancy rates in the vicinity of 50% in both public and private facilities. Low utilisation 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 utilisation. 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 excessive 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.

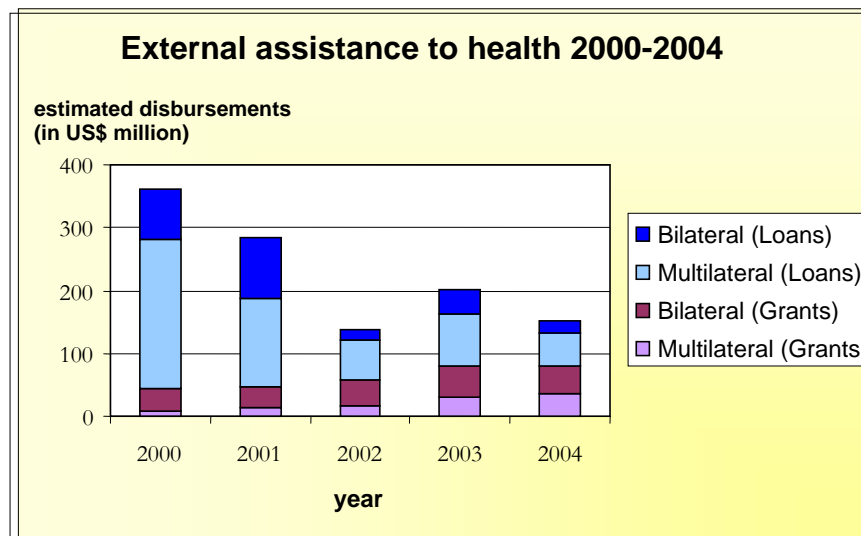
While **medicines** to treat the vast majority of tuberculosis, malaria and HIV-AIDS cases exist, drugs are not reaching everyone due to limited affordability and availability as well as other factors. Despite the presence of a strong Drug Regulatory Authority, responsible for the registration of medicines 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.

3. 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 1980's, with fluctuating foreign assistance amounts through the mid-90's. 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. Chart 2 shows estimated external assistance to the health sector as a whole (not just to the government) for the period 2000 to 2004.

Chart 2: External assistance to the health sector



Source: donor activities in Indonesia's health sector

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 4/5ths of bilateral grants given during 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 nongovernmental organizations (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 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 in the health sector.

An analysis of loans currently proposed in the Ministry of Health show that there is a growing interest in the upgrading or improvement of hospitals, with almost 3/4ths of proposed loan funds in the Department of Health's bluebook being proposed for this category. Other areas - which 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 their emphasis has shifted to building local management and clinical capacity, community empowerment, and improving operational competence. Latest projects 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 programs, and monitoring implementation and outputs. The World Bank's focus has similarly been on increasing capacity at local levels to manage the transition to regional autonomy, although some loans are still ongoing in support of water and sanitation improvements.

3.4 Global health initiatives as applied to Indonesia

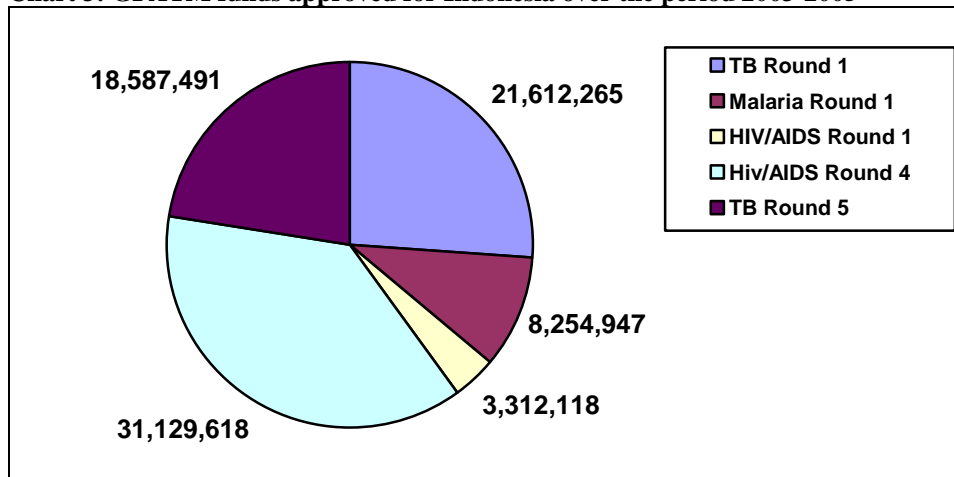
In 2003, the Global Fund to fight Aids, tuberculosis and malaria (GFATM) and the Global alliance for vaccines and immunization (GAVI) started to disburse funds earmarked for special programmes. GFATM's principal recipient is the Ministry of Health, Indonesia.

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 a forum to forge partnership 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 the individual diseases. CCM meetings are held quarterly.

WHO has displayed a leadership role in assisting Ministry of Health, Indonesia, in the preparation of GFATM proposals for rounds 1 to 5. 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 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. Since 2003, a substantial total of grant amounts was mobilized under GFATM mechanism, totalling US \$130,958,191. These were distributed as follows:

Chart 3: GFATM funds approved for Indonesia over the period 2003-2005



Furthermore, during the period 2003-2005, GAVI has 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. 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 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 UNICEF, UNFPA, ILO and FAO.

WHO, together with FAO, is taking a 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, respectively. The UN has also collectively been working together to support the national avian flu coordinating body (Coordinating Ministry of People's Welfare) through support to an inter-ministry 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 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 government of Indonesia to manage risks for, and respond effectively to, disasters. The working group meets regularly to discuss issues of common concern and identify action points for implementation. The group also aims to bring resources from the UN system and other donors together to be able to help government authorities in a coordinated manner. The UN is also developing a *joint UN post tsunami recovery strategy in Aceh and Nias*.

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 activities concentrated on development programmes. A further expansion of NGOs occurred after the fall of president Suharto'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 at village levels - regulate the presence and activities of NGOs in Indonesia.

Little information exists on the number of NGOs providing health care services and overall figures range between 8,000 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 government; small local NGOs that are the more traditional grass roots NGOs working at community level; and NGOs connected with 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 NAD providing long term support to reconstruction and rehabilitation.

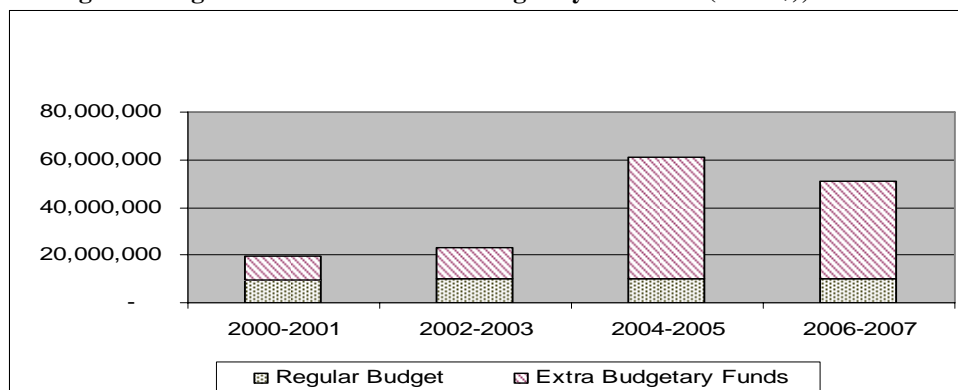
4. WHO collaborative country programmes in Indonesia

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 the 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. From 1996-1997, WHO introduced ‘umbrella’ projects aimed towards better coordination of individual projects, with linkages and products to improve accountability and measurability.

During 2000-2001 and 2002-2003 biennia, WHO strengthened technical support to programmes through the establishment of fixed term posts under two major areas, malaria and tuberculosis. Deployment of a 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 which could be implemented in many parts of the country. The need for a 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 regular budget provided US \$9.892 million in 2004–2005 biennium and allocated US \$10.127 million for the 2006-2007 biennium. Extrabudgetary 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 Dec 2004. For the 2006–2007 biennium, an extrabudgetary total of US \$40.685 million is envisaged (as at January 2007). About 30% of regular budget funds are allocated for the WHO Indonesia country office. The chart and table below display the development of regular budget country allocations and extrabudgetary funding from 2000 to date.

Chart 4: Regular budget allocations and extrabudgetary resources (in US\$), WHO Indonesia



The following table shows how regular budget funds in WHO country collaborative programmes were utilized during the 2004-2005 biennium.

Distribution of WHO regular budget, expressed in areas of priority, WHO country cooperation strategy for Indonesia

	regular budget 2004-2005 (US\$)
health policy and systems development	2,233,000
prevention and control of communicable diseases	2,572,000
noncommunicable diseases & 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, non-communicable 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, non-communicable diseases are being given increasing attention. Health promotion in areas such as tobacco and health, and occupational diseases, require WHO's support as well.

- **Technical support for emergency preparedness and response** – As Indonesia is prone to both natural and man-made emergencies, technical support and assisting government's donor coordination are deemed important to mitigate the health impact of emergencies.
- **Other technical support** including programme evaluations, assessments to identify current needs, short-term technical training and attending technical meetings.

The **strengths of WHO** country office are often reported as follows.

- **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. This supports WHO's role in donor coordination.
- **Frequent interactions with 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 possible criticisms of donor drivenness.
- **Technical backup** 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 work in Indonesia. For the last 5 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** by placement of national staff under key communicable disease programmes (tuberculosis, HIV-AIDS, polio). Furthermore, WHO maintains a presence at sub-office level in Banda Aceh, Kupang and Jayapura. This is especially critical within the framework of the decentralization process.

Some **constraints of 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 which may be considered in working with 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*.

5. WHO policy framework: global and regional directions

5.1 Global challenges in health

The General Programme of Work (GPW) is a fundamental health policy document for WHO and Member States. The 11th GPW sets out the direction for international public health for the period of 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 by 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 those 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 impact on health, especially regarding 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 shortage of funds, lack of 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: regarding prevention of disease and promotion of health, regarding 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 made it difficult to formulate and manage effective health policies and interventions. Furthermore, operational research (aimed at those most in need) is often neglected, further reducing the efficiency of service delivery in key areas.

5.2 Global health agenda

In order to reduce these gaps over the coming ten years, the 11th GPW outlines a global health agenda consisting of seven priority areas:

1. investing in health to reduce poverty
2. building individual and global health security
3. promoting universal coverage, gender equality and health-related human rights
4. tackling the determinants of health
5. strengthening health systems and equitable access
6. harnessing knowledge, science and technology
7. strengthening governance, leadership and accountability.

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

box: WHO 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
- 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:

1. Providing support to countries in moving to universal coverage with effective public health interventions
2. Strengthening global health security
3. Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health
4. Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health
5. Strengthening WHO's leadership at global and regional levels and by supporting the work of governments at country level.

WHO will implement these priorities through its Medium-term Strategic Plan (2008-2013) and the biennial programme 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 States, especially for people in greatest need.

5.3 Regional policy framework

The WHO South-East Asia Region (SEAR) 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, non-communicable diseases have become an increasingly important cause of morbidity and mortality in SEAR countries. Therefore, the global policy framework of WHO is appropriate for countries of the region, with special attention to strengthening capacity of Member States to implement priority public health interventions.

WHO South-East Asia Region has traditionally placed strong emphasis on its work in and with Member States. Of the budget provided to WHO SEAR, 75% is allocated for countries, the highest of any WHO region. The eleven SEAR countries have strong WHO country offices active in health development initiatives. WHO Regional Director recently increased 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 WHO SEARO 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.

6. Strategic agenda for WHO Indonesia

6.1 Overall goals

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 to other countries, regionally as well as globally, by offering platforms and mechanisms for exchange.

6.2 WHO strategic agenda: principal components

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 non-communicable diseases. Against this background a key objective of WHO 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 during 2007 through to 2011. In the light of country needs, government policies, activities of other development partners and WHO's own objectives, WHO country cooperation strategy for Indonesia will focus on the following strategic 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**
- 6. Partnerships, coordination and WHO country presence**

6.3 Strategic areas: an overview

1. Health policy and system development

Health policy and system development is where WHO has begun to concentrate a substantial effort during 2006-2011. 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, determining how health institutions could develop to foster effective community participation. Managerial aspects of service delivery and institutional arrangements are likely to feature as well.

Strategic objective:

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

Strategies:

1. Analyse health finance information and advocate supportive policies, including health insurance
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 regulation of public and private provision of health services
 - improving planning especially at the district level
 - improving management of essential drugs and equipment
 - promoting operational research to develop and evaluate programmes and system innovations.
3. Strengthen and institutionalise information systems with emphasis on the district level, including better monitoring and use of data
4. Strengthen 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 the public and private sectors
 - strengthening management of health facilities and clinical governance
 - improving incentives and motivating health workers, especially in remote and under-served areas, as well as for key public health functions
 - strengthening pre-service and in-service training emphasizing public health and service delivery.

2. *Prevention and control of communicable diseases*

During 2006-2011, WHO will continue to support 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 the situation 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 objective:

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

Strategies:

1. Continue providing technical support for the implementation of communicable disease programmes
2. Strengthen the management of communicable disease programmes including the development of proposals, resource mobilization, monitoring and evaluation
3. Strengthen the expanded programme of immunizations
4. Strengthen health laboratories and blood safety
5. Strengthen surveillance, response to and preparedness for disease outbreaks and pandemics, especially in the context of the International Health Regulations.

3. *Health of women, children and adolescents*

Through technical support to the new Directorates of maternal, 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 integration of nutrition in related programmes. To be able to maximize 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 objective:

promote policies and strengthen programmes to improve child, adolescent and reproductive health

Strategies:

1. provide technical support and promote scaling up of priority interventions
2. promote increased access for all (in particular the most vulnerable), to good quality preventive and curative services by public and private providers
3. advocate strengthening of national capacity to integrate gender equity and a human rights approach in policies and programmes
4. support coordination of stakeholders and resource mobilization to facilitate implementation research (or essential national health research)
5. support implementation of nutrition interventions – and their integration - in all related programmes.

4. *Noncommunicable diseases, mental health, 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, 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.

Strategic objective:

Promote public health approaches to prevention and control of non-communicable diseases, mental health and environmental health

Strategies:

1. Advocate the importance of addressing the increasing national burden of noncommunicable diseases and the key role of prevention
2. Support the monitoring in the prevalence of noncommunicable diseases and related risk factors
3. Support the development and implementation of national, intersectoral strategies for improved diet and physical activity
4. Support the development and implementation of national strategies to address disabilities especially blindness
5. Strengthen development and implementation of community-based mental health programmes

6. Support adherence to, and implementation of, WHO's Framework Convention for Tobacco Control.
7. Promote environmental aspects of health, as climate change emerges as a defining issue of our time.

5. *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 Ministry of Health and other relevant national authorities to further develop national capacity for emergency preparedness and response to public health needs.

Strategic objective:
Strengthen emergency preparedness and response

Strategies:

1. Encourage adoption of international best practices and minimum standards in emergency management
2. Support development of emergency management capacity in government ministries
3. Emphasize emergency mitigation and preparedness including better hazard and vulnerability assessments
4. Mobilize extrabudgetary resources to emergency relief activities in support of disaster affected populations
5. Promote the prevention of, and response to, injuries and accidents.

6. *Partnerships, coordination and WHO country presence*

WHO country presence 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. WHO continues to advocate 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. The Organization aims to facilitate information sharing among a range of health actors, including technical updates and situation reports.

Strategic objective:
Promote partnerships, coordination and WHO country presence

Strategies:

1. Advocate WHO policies, roles and functions to government, international community and United Nations system in Indonesia
2. Support Ministry of Health in coordinating health partners and in fostering intersectoral collaboration
3. Support investment in health in Indonesia, from national and international sources
4. Strengthen partnerships among health actors as appropriate, for example NGOs, UN and bilateral agencies, universities and development banks
5. Facilitate exchange of information about local level health initiatives to influence national policies and programmes
6. Improve knowledge management in WHO including the dissemination of relevant public health information.

7. Implementing the strategic agenda: implications for the WHO secretariat

To achieve the strategic objectives outlined in the preceding section 6 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 country cooperation strategy effectively. It will entail changes both in the country office and in the timely and appropriate support to be provided by WHO SEARO, WHO Headquarters and WHO elsewhere in the world.

7.1 WHO country office

Strategic area 1 - Health policy and system development: With the continued focus on strengthening health systems during 2006-2011, 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.

Strategic area 2 – Prevention and control of communicable diseases: Established and emerging infectious diseases require the experience and assistance of experts who have faced comparable situations elsewhere. It is important for 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 adjustments likely.

Strategic 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 which 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.

Strategic area 4 - Non-communicable 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 non communicable diseases, mental health, injury and tobacco use, higher on the Indonesia 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.

Strategic 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 to this: 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.

Strategic area 6 – Partnerships, coordination and WHO country presence. Sufficient technical and support personnel are key WHO resource to assist in the delivery of collaborative programmes and in the mobilization of additional resources. Furthermore, coordination and partnerships require 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.

Table 3: Current and proposed staffing pattern to implement the WHO country cooperation strategy

	current country staff				proposed country staff			
	LTS		NPO		LTS		NPO	
	RB	VC	RB	VC	RB	VC	RB	VC
1. Health policy and systems development								
district health systems**	1				1		1	
health financing and social health insurance					1			1
human resources for health**	1			1*	1			1
2. Prevention and control of communicable diseases								
tuberculosis	1	2			1	2		2
HIV-AIDS	1	1		2*	1	1		2
malaria	1			1*	1			1
other vector borne diseases						1		1
communicable disease surveillance & response				1*		1	1	
expanded programme of immunizations		2			1	2		1
3. Health of women, children and adolescents								
reproductive health	1				1		1	1
child health	1			1*	1			
adolescent health								1
nutrition				1*				1
4. Noncommunicable diseases, mental health, health and environment								
noncommunicable diseases			1				1	
mental health				1*				1
health and environment, and health promotion	1				1			1
5. Emergency preparedness and response								
emergency preparedness and response	1			1*	1	1	1	1
6. Partnerships, coordination and WHO country presence								
WR	1				1			
planning and policy	1				1			
administrative support services	1				2			
TO monitoring and evaluation**	1				1			
media, IT and information management				1*			1	2
total	13	5	1	10*	16	8	6	17

RB: regular budget VC: voluntary contributions (extrabudgetary resources)

* national professional officers

** vacant posts

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 multi-country 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, 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 in the planning process early on, 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 CCS will provide the basis for mobilizing further resources both for the government and for WHO's own programmes.

However, while the scenario of increased extra budgetary resource is likely to be good in Indonesia, 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 to the donors. In addition, donors expect accountability if they are providing specific funds for various projects. Dependency on extra budgetary 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 extra budgetary funding must consider integration of the activities into the WHO workplan as opposed to a "project approach" and the smooth execution of administrative procedures. Delegation of authority within WHO SEAR, helped in responding to needs, despite further increased workload. However, issues requiring attention remain, for example recruitment of staff and procurement of supplies which often result in major implementing delays and require extensive involvement of technical *and* administrative country office staff. WHO SEARO and WHO HQ could further improve coordination as well as administrative and technical support to the country office.

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Abbreviations

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>Gerakon Aceh Merdeka</i> (Free Aceh Movement)
GAVI	Global alliance for vaccines and immunization
GFATM	Global fund to fight 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)
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	draft medium-term strategic plan 2008-2013 (of WHO)

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
WHO SEARO	World Health Organization South East Asia Regional Office
TB	tuberculosis
UN	United Nations
UNICEF	United Nations International Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization