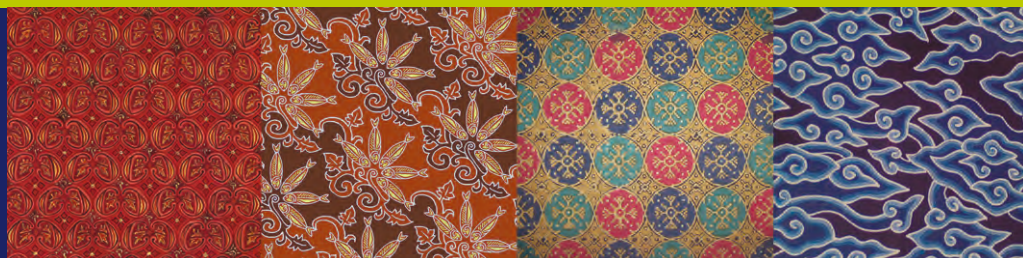


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Contents

Preface.....	v
Foreword	vii
Acronyms.....	ix
Executive summary.....	xi
1. Introduction	1
2. Health and Development Challenges, Attributes of the National Health Policies and Plans	3
3. Development Cooperation and Partnerships	16
4. Review of WHO cooperation over the past CCS cycle	20
5. The Strategic Agenda for WHO Cooperation	28
6. Implementing the Strategic Agenda: Implications for the entire Secretariat	37

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 States of the Region. The WHO Country Cooperation Strategy is WHO's medium-term strategic vision to guide its work in and with a country. It aims at harmonizing cooperation and support among WHO and other UN agencies and development partners. It also guides on how WHO can best support health development in a country taking into consideration the regional and global priorities of the Organization.

Indonesia was one of the first countries to develop a Country Cooperation Strategy (CCS). The first CCS for Indonesia covered the period 2001 to 2005. WHO prepared its Second Country Cooperation Strategy covering the period 2008 to 2013. The second CCS was implemented during a period when economic growth in Indonesia gained good momentum and during which time the country was classified as a middle-income country.

Recent analysis on the current health situation, the likely health scenarios through 2019, new priorities of the Ministry of Health, especially commitments for universal health coverage, and the World Health Organization's General Programme Work for the period 2014–2018 form the basis for this Third Country Cooperation Strategy.

We recognize the need for a strong WHO country office to work closely with key Indonesian counterparts and partners, especially in other United Nations agencies involved in the existing United Nations Development Framework (UNPDF). This cooperation should consider local conditions and emerging priorities, such as noncommunicable diseases, while continuing to assist with reducing the incidence of measles and neglected tropical diseases, as well as to help ensure that the population is protected against outbreaks and natural disasters.

I would like to thank all those who have contributed to developing this WHO Country Cooperation Strategy and to ensure that the WHO Regional Office and headquarters are fully committed to its implementation. We appreciate the inputs and suggestions received from the Ministry of Health, key health experts and our health development partners in the country, and will continue to work closely with them. This consultative process will ensure that WHO contributions will maximize support to Indonesia's health development efforts over the next five years. Our joint efforts should be aimed at achieving the maximum health benefits for people living in the world's largest archipelago.



Dr Poonam Khetrpal Singh
Regional Director
WHO South-East Asia Region

Foreword



The global WHO corporate strategy developed in 2000 emphasizes, *inter alia*, the development of WHO country cooperation strategies to foster a corporate and more strategic approach to country work. The WHO Country Cooperation Strategy for Indonesia 2002–2005 was one of the first five strategies to be implemented by Member States of WHO. The second Indonesian Country Cooperation Strategy was developed for 2007–2011 and was later updated to include 2013. As the Indonesian economy and health sector continue to develop, the roles of Indonesia's health partners should evolve to ensure that they maximize support for health in the country. Therefore, this Third Country Cooperation Strategy reflects changes in Indonesia and outlines the appropriate support of WHO for 2014–2019.

This Third Country Cooperation Strategy has been developed in close collaboration with the Ministry of Health and development partners with additional inputs and guidance from WHO headquarters and the Regional Office. Drafts of the strategy were shared and discussed with the Center for International Cooperation and Bureau of Planning, Ministry of Health, Government of Indonesia.

As a result of a thorough review, five strategic priorities for WHO country cooperation for 2014–2019 are as follows:

- (1) Address the challenges of communicable diseases and reach the 'Post-2015 Agenda' targets
- (2) Address the challenge of noncommunicable diseases and their modifiable risk factors
- (3) Improve maternal, neonatal, child and adolescent health through increasing access to quality services
- (4) Ensure Indonesia achieves universal health coverage (UHC)
- (5) Enable capacity for preparedness and response to public health emergencies and disasters.

In addition, a set of main focus areas and strategic approaches were developed for each of these strategic priorities to guide implementation of WHO's collaborative programmes in the country.

I am pleased to acknowledge the hard work of the country office staff members and their counterparts in reviewing the current health situation and developing this country cooperation strategy. In addition, I am grateful for the constructive comments from the South-East Asia Regional Office and WHO headquarters.

Implementation of this country cooperation strategy will rely on close support from other offices of WHO. Finally, I would like to express our sincere gratitude for the time and input of the Ministry of Health, the United Nations system, as well as other national and international stakeholders. I trust that this country cooperation strategy will successfully guide the work of WHO to support efforts to improve the health of the people of Indonesia.



Dr Khanchit Limpakarnjanarat
WHO Representative to
Indonesia

Acronyms

AC	Assessed Contributions
AFHS	Adolescent Friendly Health Services
ASEAN	Association of Southeast Asian Nations
BAPPENAS	National Development Planning Agency
BEmONC	Basic Emergency Obstetric and Newborn CARE
BKKBN	National Population and Family Planning Board
BPS	Statistics Indonesia (Badan Pusat Statistik)
CCS	Country Cooperation Strategy
CDC	Center for Disease Control and Prevention
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CRS	Congenital Rubella Syndrome
DFAT	Australia's Department of Foreign Affairs and Trade
DTP	Diphtheria Pertussis and Tetanus
EPI	Expanded Programme of Immunizations
G6PD	Glucose-6-Phosphate Dehydrogenase Deficiency
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GPW	WHO's 12th General Programme of Work
GTZ	German Technical Cooperation Agency
Hib	Haemophilus Influenza Type B Vaccine.
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HPV	Human Papilloma Virus
HR	Human resource
IHR	International Health Regulations ((2005)
IMCI	Integrated Management of Childhood Illnesses

IOM	International Organization for Migration
KNCV	Tuberculosis Foundation
LMIC	Lower-Middle-Income Country
MCC	Millennium Challenge Corporation
MDGs	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
NCD	Noncommunicable Diseases
NIH	National Institutes of Health
NPO	National Professional Officers
NTDs	Neglected Tropical Diseases
NTT	Nusa Tenggara Timor
PEN	Package of Essential Noncommunicable Disease
<i>RENSTRA</i>	Strategic Plan of Ministry of Health, Government of Indonesia
<i>RISKESDAS</i>	<i>Riset Kesehatan Dasar</i>
RPJMN	Medium-Term Development Plan
SHA	System of Health Accounts
SHP	School Health Programmes
SSA	Special Service Agreements
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TNP	Temporary National Professionals
UHC	Universal Health Coverage
UNCT	United Nations Country Team
UNDAF	UN Development Assistance Framework
UNDP	United Nations Development Programme
UNPDF	UN Partnership for Development Framework
UNPRPD MDTF	UN Partnership to promote the Rights of Persons with Disabilities Multi-Donor Trust Fund
USAID	US Agency for International Development
VBDs	Vector Borne Diseases
VC	Voluntary Contributions
WHO-FCTC	WHO Framework Convention on Tobacco Control

Executive summary

Indonesia has made steady progress in improving the health and life expectancy of its citizens. However, there has been a slowdown in these improvements, especially over the last five years. This is most notable in Indonesia's inability to reduce maternal mortality ratios and neonatal mortality in line with the progress of neighbouring countries. Tuberculosis remains the second highest cause of premature deaths and HIV/AIDS prevalence continues to increase. At the same time, noncommunicable diseases are increasing at an alarming rate, with 71% of deaths in 2012 due to NCDs. There are concerns about the quality of care throughout the health system. At the same time, Indonesia is making a major commitment to universal health coverage (UHC) by strengthening its health insurance system with special attention to the poor. The Indonesian Government is committed to overcoming these issues and continuing health improvements through its forthcoming medium-term strategic plan (2015–2019).

A review of the work of the WHO Country Office during the previous Country Cooperation Strategy (CCS) 2007–2013 showed that 70 % of programme expenditures were for communicable disease control. This was largely due to the extensive funding of voluntary contributions supporting mostly communicable disease projects. Over the last six years there has been a trend of decreasing funds for work in the Country Office. This closely follows the trend of WHO's health partners in the country where Indonesia's increasing economic development enables the government to fund most health services and programmes. In addition, the private sector in health is growing quickly, especially in the number of private hospitals and health providers. Overall, this stresses the need for a more strategic approach to the work of WHO in Indonesia emphasizing technical support for Indonesia's efforts to solve key constraints in the health sector.

This CCS covers the period 2014–2019 in order to coincide with the government's planning cycle and WHO's 12th General Programme of Work. It sets out a Strategic Agenda with the following five Strategic Priorities:

- (1) Address the challenges of communicable diseases and reach the 'Post 2015 Agenda' targets
- (2) Address the challenge of noncommunicable diseases and their modifiable risk factors
- (3) Improve maternal, neonatal, child and adolescent health through increasing access to quality services
- (4) Ensure that Indonesia achieves universal health coverage (UHC)
- (5) Enable capacity for preparedness and response to public health emergencies and disasters.

Implementation of this Strategic Agenda will start during the 2014–2015 biennium with appropriate revisions in current workplans. While there is still a need for WHO support in controlling communicable diseases and assisting preparations for health emergencies, there will be increasing emphasis on noncommunicable diseases including mental and neurological disorders, maternal and neonatal health especially involving the quality of services, and health systems work both for UHC as well as the quality of services and human resources. Since the Country Office has a large technical staff, current positions and their terms of reference will be reviewed to align them with the new Strategic Agenda, encouraging work among technical disciplines in the Country Office and utilizing support from WHO in the Regional Offices and headquarters. Special attention will also be put on ensuring close support and capacity strengthening for the Ministry of Health, with special attention on the appropriate role of the private sector and the rationalization of the health system and services in a decentralized environment. Finally, the WHO Country Office will continue to work closely with its health partners in the country, especially with United Nations agencies.

Chapter 1

Introduction

The Country Cooperation Strategies of the World Health Organization are developed for a period of four to six years. Based on an analysis the country's health situation, as well as the priorities of the Ministry of Health and other partners working in the health sector, they set out a strategic agenda for WHO in that period. While the Organization is involved with all aspects of health in support of its Member States, it is recognized that the work of WHO in each country needs to be more strategic, contributing in specific areas where WHO has the comparative advantage for benefiting health in the country. The Country Cooperation Strategy briefly reviews the current health situations in the country, the priorities of the government in the health sector, the recent work of WHO as well as its major health partners, specifying the expected contributions to the country in the WHO Country Office's Strategic Agenda. This involves all levels of WHO since contributions at the country level depend on support from the Regional Office as well as headquarters in Geneva, guided by decisions of the Organization's governing bodies. At the same time, the WHO priorities at the country level should also drive the global priorities of WHO itself since the goals of the Organization should be to support its Member States.

Indonesia was one of the first countries to develop a Country Cooperation Strategy (CCS) covering the period 2001–2005. The second CCS in Indonesia was developed in 2007 for the period 2007–2011, and it was later extended to 2013. Efforts to develop the third CCS for Indonesia were delayed due to major changes in WHO, especially WHO reform initiatives and the development of the 12th General Programme of Work (GPW) covering the period 2014–2019.

On the side of the Indonesian Government, the third five-year phase (2015–2019) of the country's long-term plan (2005–2025) is being developed along with the Ministry of Health's strategic plan covering this same period, 2015–2019. Developing Indonesia's CCS at the same time ensures that it is aligned with planning cycles of both WHO and the Indonesian Government. In order to coincide with WHO's current biennium budget and planning cycle for 2014–2015 as well as the period of the 12th GPW, this third CCS will cover the period 2014–2019. This implies that the CCS will be used immediately to modified current workplans and budgets to start implementing the new CCS.

Work to develop a draft of the new CCS started in the middle of 2013 with a working group established in the Country Office and representation from the Ministry of Health. Intensified CCS efforts took place from May to July 2014, with a consultant recruited to assist in developing a draft of the CCS. This period also coincided with the finalization of the Indonesian Government's own efforts to review the health situation in a comprehensive health sector review as the basis for its plans for 2014–2019. During this intensive period to develop the CCS, the first stage was to review WHO's work during the previous CCS. Most attention was put on the financial implementation from 2010–2013 and a review of the major achievements during the CCS period. Consultations were held with the Ministry of Health, the National Planning Agency (BAPPENAS), university researchers and WHO's major health partners in Indonesia concentrating on their recent experience working with WHO and recommendations for future WHO work in Indonesia. In addition to the working group, all WHO technical staff members were involved in the process to review draft documents and participate in a workshop, led by the WHO Representative, to develop the Strategic Agenda for the CCS. The draft of the CCS was further reviewed by the Ministry of Health and Regional Office staff members and the Regional Director, with further modifications made as appropriate. Although the CCS draft was completed before the appointment of the new government cabinet in Indonesia, it was decided to wait for the CCS to be reviewed and signed by the newly appointed Minister of Health.

Indonesia's steady economic development and rising GDP have made it possible for the Government to fund most health services and programmes in the country. Therefore, the role of international health partners has changed substantially over the last decade. Indonesia no longer needs the financial support of its partners such as development banks. Nonetheless, the country appreciates the support of its health partners in identifying key constraints in the health sector, along with innovations and solutions that can be expanded to country programmes and policies. The WHO Country Office's role follows this trend and its work aims to maximize technical support for these efforts.

In the following sections of the CCS, there will be a brief review of the current health situation, the work of WHO and other health partners, followed by an outline of WHO's Strategic Agenda for 2014–2019 and how it will be implemented. This document is meant to be brief and to spell out strategies for WHO in the country. Detailed budgets and workplans for implementing the CCS will be presented in the Country Office's biennium budgets and workplans.

Chapter 2

Health and Development Challenges, Attributes of the National Health Policies and Plans

Population and economic conditions

Indonesia has an estimated 2014 population of 250 million spread out over half of its 17 000 islands, making it the fourth most populous country and the third largest democracy. About 60 % of this population is densely settled on the islands of Java and Bali that encompass only 7% of the country's land area. In 2010, 50.2% (http://www.bps.go.id/tab_sub/view.php?kat=1&tabel=1&daftar=1&id_subyek=12¬ab=14) of the population lived in rural areas, compared with 69% in 1990. Over the last decade, the economy grew at a rate of over 5% a year and this is expected to increase to 6% or 7% over the next three to five years. In 2012, per capita income was about US\$ 3580 per year (<http://data.worldbank.org/country/indonesia>), thus classifying Indonesia as a lower-middle-income country (LMIC). The World Bank estimates that in 2014 about 11.3% (<http://data.worldbank.org/indicator/SI.POV.NAHC/countries/ID?display=default>) of people live on less than US\$ 1.25 per day and 43.3% of the population lived below US\$ 2 per day in 2011 (<http://data.worldbank.org/indicator/SI.POV.2DAY/countries/ID?display=default>).

Health situation in Indonesia

Over the last few decades, the health of Indonesians has improved substantially with life expectancy increasing from 62 years (1990) to 71 years (2012) (World Health Organization, 2014). Below are the areas where health has improved, but where there are still challenges for the future.

1. Communicable diseases

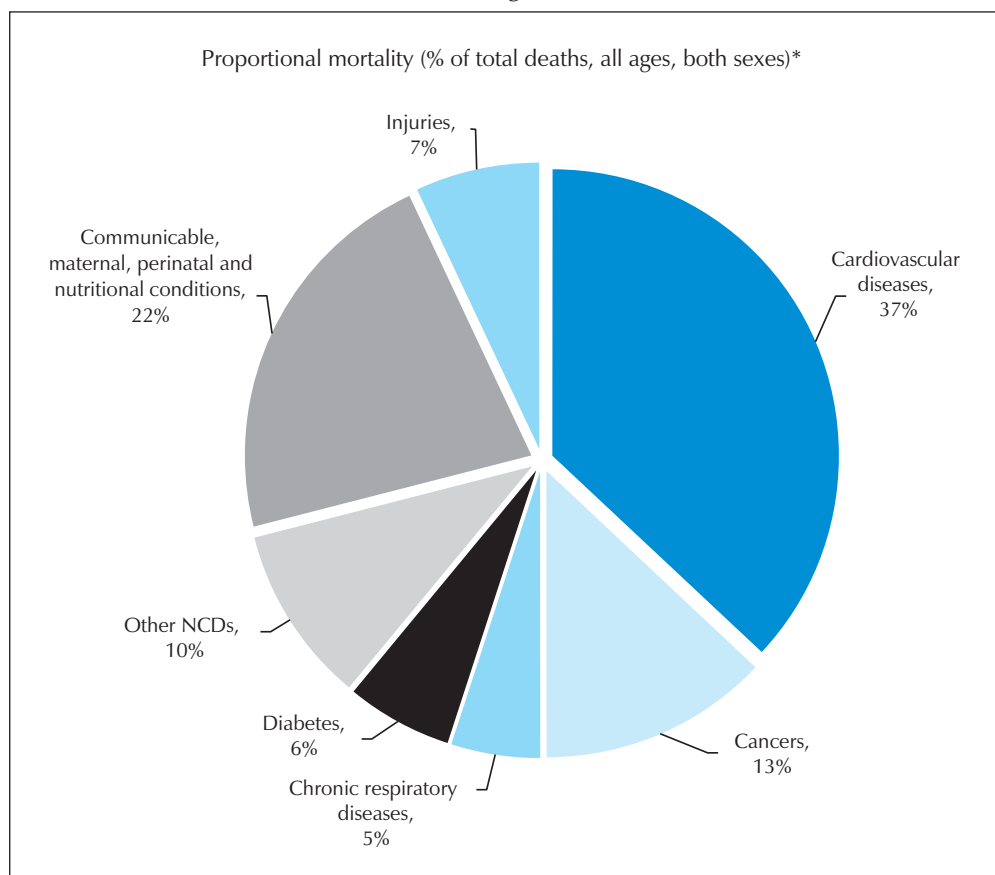
Significant progress has been made in detecting and treating tuberculosis in the last two decades with the prevalence of TB dropping from 474 per 100 000 population in 2000 to 272 in 2013 with the case detection rate increasing from 20% to 72% over the same period. However, with a TB mortality rate of 25 per 100 000 population, it is estimated that about 64 000 people died of TB in 2013 (World Health Organization, 2014), making it the second highest cause of premature death (Institute for Health Metrics and Evaluation, 2013) and multi-drug resistant TB is an increasing threat. The prevalence of HIV/AIDS has increased from 39 per 100 000 population in 2001 to 245 in 2012 (World Health Organization, 2014) with especially high rates in the provinces of Papua and in high-risk groups. Although 39% of the population lives in malaria-free areas of the country, mostly in the provinces in Bali and Java, 17% are in high-transmission areas, especially the eastern provinces of Papua, Maluku, Sulawesi and Nusa Tenggara, and 44% are in low transmission areas (World Health Organization, 2013). Interventions have been scaled up to prevent and treat malaria as well as to strengthen malaria surveillance. It is targeted to eliminate malaria by 2030. **Neglected tropical diseases** remain a problem with leprosy, lymphatic filariasis (to be eliminated through mass drug administration), schistosomiasis and yaws in specific areas of the country. The number of new cases of **leprosy** did not change significantly during the years of 2005–2012, when the number was 18 994, the third highest country in the world after India and Brazil (World Health Organization, No. 35, 2013, 88). **Dengue** and **chikungunya** are increasing problems throughout the country. Indonesia has been free of **polio** since 2006 and a strong AFP polio surveillance system is in place. The routine immunization system has improved as measured by increased DPT3 coverage. **Measles** coverage among one-year olds has increased from 58% in 1990 to 80% in 2012 (World Health Organization, 2014) and a case-based measles surveillance has been developed and strengthened in all provinces of Indonesia. Hib vaccine has been introduced in a Pentavalent product that also provides booster doses for DTP and measles as part of the national childhood immunization schedule.

2. Noncommunicable diseases, nutrition, mental health and injuries

Using age-standardized mortality rates, Figure 2.1 shows that 78% of all deaths in Indonesia during 2012 were due to noncommunicable diseases and injuries. Cerebrovascular disease is now the highest cause of premature deaths, and road injuries is third. This is in contrast to 1990 when the top three causes of premature deaths were all communicable diseases. Besides this, noncommunicable disease and injuries, ischemic heart disease, diabetes and cirrhosis were all in the top 10 causes of premature deaths in 2010. Major depressive disorders was the second highest of cause of disability in the same year. The three major risk factors for noncommunicable diseases were first diet, second highest blood pressure and third tobacco smoking (Institute for

Health Metrics and Evaluation, 2013). Given Indonesia’s rapid development and gradual reduction of communicable diseases, the importance of noncommunicable diseases, mental health and injuries to mortality, morbidity and disability is certain to increase.

Figure 2.1: Percentage of all deaths in Indonesia by cause in 2012
(World Health Organization, 2014)



Substantial progress has been made in Millennium Development Goal 1c “Halve, between 1990 and 2015, the proportion of people who suffer from hunger”, specifically the indicator of the percentage of under-five-year-olds who have moderately or severely low weight-for-age, which was 31% in 1989. This proportion of underweight children has been reduced to 19.6% in 2013 (Badan Penelitian dan Pengembangan Kesehatan, Kementerian Kesehatan RI, 2013). Using an annual rate of decrease of 0.475%, it is estimated that the 2015 percentage will be 18.6%, still above the 2015 MDG target of 15.5% (BAPPENAS, National Development Planning Agency, 2012). Stunting, or low height-for-age, has now become the major indicator for nutritional status of under-fives.

It is estimated that stunting is associated with 14.7% of deaths of children aged 1 to 59 months, slightly more than the 14.4% due to underweight in the same age group. Furthermore, stunting is also associated with motor and cognitive development of the child (Robert E. Black, 2013). Growth faltering for height starts during pregnancy and occurs during the first 24 months of life, thus interventions must be targeted at 1000 days, including gestation and the first two years of life (World Health Organization, 2010). The proportion of stunting in under-fives was 36.8% in 2007, 35.6% in 2010 and 37.2% in 2013 (Badan Penelitian dan Pengembangan Kesehatan, Kementerian Kesehatan RI, 2013), higher than the 27.4% for South-East Asia in 2011 (UNICEF-WHO-The World Bank, 2012). Iron deficiency anemia remains a problem especially with its association to maternal mortality. Iron and folic acid supplementation in Indonesia has been shown to reduce the risk of newborn deaths by 39%, especially during the first day of life (Michael J. Dibley, Christiana R. Titaley, 2012). Finally, increasing obesity and poor quality diets are major risk factors for noncommunicable diseases. Indonesia is a member of the Scaling-Up Nutrition Initiative and has made nutrition a priority for the country with a multi-sectoral platform to focus on the one thousand days around births.

3. Maternal, neonatal, child and adolescent health

Indonesia is strongly committed to achieving Millennium Development Goal 4 (reduce by two thirds the under-five (U5) mortality rate) between 1990 and 2015. In 1991, the U5 mortality rate was estimated to be 97 with an infant mortality rate (IMR) of 68 per 1000 live births, with a target of achieving an U5 rate of 32 by 2015 (IMR target of 23). Substantial progress has been made in lowering child mortality. However, since 2000, the rate of lowering U5 mortality has decreased with limited progress especially in neonatal mortality, which was responsible for 32% of U5 mortality in 1991 but increased to 59% in 2012 (Statistics Indonesia (Badan Pusat Statistik—BPS), National Population and Family Planning Board (BKKBN), 2013). It is now estimated that Indonesia will reach a U5 mortality rate of 34 and an IMR of 27, slightly above the targets of 32 and 23 respectively (Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia, 2013).

Indonesia's success in achieving Millennium Development Goal 5 (reduce by three fourths the maternal mortality ratio (MMR)) has been mixed. An estimate of 390 maternal deaths per 100 000 live births was the 1991 baseline with an MMR target of 102 by 2015. All current estimates of MMR are substantially higher than this target and by 2015 MMR are estimated to be 230, over twice the target (Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia, 2013) and it is estimated that there were 12 000 maternal deaths in 2009. To improve access to maternal and newborn care, midwives provide obstetric and neonatal care at the village level. At least four health centres in each district are selected as facilities to provide basic emergency obstetric and newborn care (BEmONC), supported by one district hospital providing comprehensive emergency obstetric and newborn care (CEmONC). Despite achievements of increased

Table 2.1: Progress in key Millennium Development Goal (MDG) indicators

MDG indicator	1989–1991 baseline*	MDG target*	Estimate for 2015#
Underweight U5 children	31	15.5	18.6
Infant mortality rate	68	23	27
Under-five mortality rate	97	32	34
Maternal mortality ratio	390	102	230
HIV/AIDS prevalence among total population (per 100 000)	39 (2001)	decrease	245 (2012)
Prevalence rate of Tuberculosis (per 100 000)	443	Halt and reverse	272 (2013)

*Ministry of National Development Planning/National Development Planning Agency (BAPPENAS), *Report on the Achievement of Millennium Development Goals in Indonesia 2011, 2012*. #National Research Council, United States National Academies of Sciences, *Reducing Maternal and Neonatal Mortality in Indonesia*. 2013; HIV/AIDS and TB (World Health Organization, 2014).

access to skilled birth attendance and antenatal and postnatal care, the clinical skills of midwives are limited with retention difficult in remote areas. Challenges remain in accessing quality care, leading to the “three delays” (decision to seek care, identifying and reaching a medical facility, and receipt of appropriate and adequate treatment) in safe motherhood.

The adolescent population in Indonesia is about 18%. However, there are no guidelines for planning and financing the development of adolescent friendly health services (AFHS) at the district level, incomplete implementation of school health programmes (SHP), and no data and indicators related to school health programmes for preconception care and adolescent mental health. Equitable access of adolescents and unmarried girls to reproductive health and family planning information services is hampered by the misinterpretation of some regulations and decrees restricting access to contraceptive services in public facilities, although some are available from the private sector. A ministerial decree authorizes a minimal form of female genital mutilation to be performed only by doctors, nurses or midwives but this practice is sometimes extended.

4. Universal health coverage

Despite Indonesia’s rapid economic growth over the last decade, health expenditures remain relatively low. In 2012, 3% (<http://apps.who.int/nha/database/ViewData/Indicators/en>) of the country’s GDP was spent on health, a substantial increase from less than 1% prior to 2007 (The World Bank, 2008). However, this is still a lower percentage of GDP than for all countries in the WHO region of South-East Asia except Myanmar. For the same year, this amounts to per capita total health expenditures of US\$ 99 with government expenditures of US\$ 38 or 38% of the total, also the second

lowest percentage of government spending on health in the region (World Health Organization, 2014). The share of government spending allocated to health is 7%, less than half the Abuja target of 15% (http://apps.who.int/nha/database/Country_Profile/Index/en), reflecting a relatively low priority of public spending on health and making it more difficult to achieve universal health coverage. Out-of-pocket expenditures on health remain about 45% of total expenditures despite significant advances in coverage of health insurances schemes from 15% in 1995 to 40% in 2010, increasing to 49.5% in 2013 (Badan Penelitian dan Pengembangan Kesehatan, Kementerian Kesehatan RI, 2013). Most of the out-of-pocket expenditures are made by those with higher incomes, with half of out-of-pocket expenditures made by the population in the highest three income deciles and only 15% in the lowest three deciles (Pandu Harimurti, 2013). This indicates high rates of utilization of private sector providers and facilities by those with higher incomes while those with lower incomes did not seek health care or used less expensive health facilities. In 2014, of the 2322 hospitals in Indonesia, 31% were private, non-profit and 29% were for-profit hospitals (Kementerian Kesehatan RI).

Table 2.2: Coverage of health services and key outcomes by region and economic group

Group	Maternal mortality ratio	Home delivery (%)	Neonatal mortality rate	Infant mortality rate	DPT3 coverage	Measles coverage
Highest quintile	–	12	10	17	85	90
Lowest quintile	–	69	29	52	52	65
Urban	–	19	15	26	77	82
Rural	–	52	24	40	67	78
Sumatera	262	44	21	33	66	73
Java - Bali	227	24	18	30	78	85
Kalimantan	340	57	21	35	66	75
Sulawesi	459	58	19	38	67	77
Eastern Indonesia	434	54	29	52	62	76
Indonesia	278	34	19	32	72	80

Sources: Maternal mortality ratio was based on 2010 census (Badan Penelitian dan Pengembangan Kesehatan, Kementerian Kesehatan, 2012); all others calculated from IDHS 2012 (Statistics Indonesia (Badan Pusat Statistik—BPS), National Population and Family Planning Board (BKKBN), 2013).

In 2004, the Indonesian Government passed legislation guaranteeing universal access to basic health services. However, Table 2.2 shows the difficulties in delivering health services to all Indonesians. This table shows that the major factor in health

outcomes and service delivery is related to income. Second, rural areas tend to have worse outcomes and lower service coverage rates. Finally, provinces in the eastern part of Indonesia and Sulawesi tend to be worse off than Java and Bali. For example, it is estimated that the maternal mortality ratio in the provinces in Sulawesi is twice that of Java and Bali. With the population in these eastern islands more dispersed, health services and programmes are more difficult to deliver.

The Indonesian Government has recognized that the poor were often unable to use health facilities and risk catastrophic health expenditures, requiring a major initiative to ensure access. In 2005, a health insurance scheme (*Askeskin*) was started where the poor and near-poor were enrolled with the government paying the monthly premium. Participants in this scheme had access to both primary health facilities and hospitals for referrals. In 2007, this scheme was renamed *Jamkesmas* and in 2014, this insurance scheme was combined with insurance for civil-servants and private sector schemes under one unified insurance scheme. Anyone is eligible to enroll in *Jamkesmas* by paying the monthly insurance fee of about US\$ 20 per person per year. The government distributes insurance cards and pays the premiums targeting approximately one third of the population considered poor or near-poor, requiring various methods to identify poor households. In 2010 it was estimated that 40% of the poor were covered by health insurance, although about 52% of government-subsidized *Jamkesmas* participants were not poor (Pandu Harimurti, 2013). Since this scheme is designed for public facilities, the reimbursement rates do not cover the full costs of services, since salaries and facility costs are paid by the government. However, participants can access some non-profit hospitals with the hospitals subsidizing the difference between reimbursements and actual costs.

In 2001, Indonesia instituted major reforms to decentralize the government. Health services, along with a number of other government functions, were decentralized to the district level. The central government was no longer responsible for the development of health facilities and programmes. Furthermore, since this decentralization bypassed the provincial level, the authority of the provincial health offices to support and supervise district health offices and programmes was diminished. Central block grants were still provided to districts, but district health departments and political leaders have more authority to implement programmes and support health facilities to meet the needs of the district's population. While this has had many positive effects, it probably has increased the disparity in health services among districts. Some districts may allocate funds for hospital facilities at the expenses of public health interventions. Furthermore, the roles of the provincial health offices and the central Ministry of Health to support health services and programmes are still not fully optimized. It has also made it more difficult for national health information systems to collect data from all districts.

Table 2.3: Health Workers (per 10 000 population) in Indonesia compared with other countries and the Region (World Health Organization, 2014)

Country/Region	Physicians	Nurses and midwives	Dentistry	Pharmaceutical	Psychiatrists
Bangladesh	3.6	2.2	0.3	0.6	<0.05
India	7.0	17.1	1.0	5.0	<0.05
Indonesia	2.0	13.8	1.0	1.0	<0.05
Malaysia	12.0	32.8	3.6	4.3	0.1
Sri Lanka	6.8	16.4	0.8	0.4	<0.05
Thailand	3.9	20.8	2.6	1.3	<0.05
Vietnam	11.6	11.4	–	3.1	0.1
LMIC	7.8	17.8	1.2	4.2	0.1
SEARO	5.9	15.3	1.0	3.8	<0.05

One of the main issues for achieving universal health coverage is human resources. As shown in Table 2.3, Indonesia has a severe shortage of physicians, especially specialists, and would need to increase the number three-fold in order to meet the regional average. The situation for nurses and midwives is better with Indonesia only slightly below the regional average. The shortage of personnel is complicated by the situation where many health workers, especially physicians, work in both the public and private sectors in order to supplement low government salaries. This often creates a conflict of interests affecting the time and quality of services these workers provide in the public sector. Compounding shortages is the tendency of health personnel to work in urban areas where facilities and services are better. Pre-service training has expanded rapidly in recent years but this has resulted in issues of the quality of training and accreditation of schools. Decentralization of the health system has also made it more difficult to implement in-service training, vital to ensuring the quality of services, as well as to collect and analyze the number and placement of health workers.

5. Preparedness and response to public health emergencies and disasters

During the last decade, Indonesia experienced several major health emergencies. Some of these were due to natural disasters, such as a tsunamis, volcanic eruptions, floods or earthquakes. Since Indonesia is vulnerable to earthquakes and volcanic eruptions as well as monsoon rains, it is likely that Indonesia will experience similar emergencies in the future. Attention has been put on preparedness both at the national and local levels, as well as community resilience and psychosocial support to prepare for disasters, especially in high-risk areas. Besides natural disasters, there have been other health emergencies

due to disease outbreaks such as avian influenza. These emergencies require a strong surveillance system, including laboratory support, throughout the country to ensure early detection of outbreaks and effective action to limit the scope of these diseases. Indonesia has been implementing interventions to improve the core capacities required for the International Health Regulations (IHR (2005)) in order to detect, verify, assess, inform and respond to events of national and international concern. The country has successfully implemented the minimum core capacities required for IHR (2005) and is now moving forward to maintain and strengthen these.

Government policies and plans

The National Development Planning Agency (BAPPENAS) has developed a long-term plan for national development covering the period 2005–2025. For each five-year period of this long-term plan, BAPPENAS develops a medium-term plan called the RPJMN. Currently BAPPENAS is preparing the RPJMN III covering the period 2015–2019, coinciding with the period of this Country Cooperation Strategy. For the health section of this plan, BAPPENAS conducted an extensive situation analysis of the health sector and established the following eleven **strategic issues** for health over the coming five years:

- (1) To improve the health of mothers, children, adolescents and the aging
- (2) To improve reproductive health and family planning
- (3) To improve the nutritional status of the community
- (4) To control diseases and improve environmental health
- (5) To fulfill the supplies of pharmaceutical, medical equipment and ensure the safety of food and drugs
- (6) To improve health promotion and increase community participation
- (7) To develop national health insurance
- (8) To increase the access to primary health care and quality referral services
- (9) To ensure adequate human resources for health
- (10) To improve management, research and development, and information systems
- (11) To develop and increase the effectiveness of health financing

Based on the strategic issues, the *RPJMN III* establishes four **major goals** in health for 2015–2019, with specific targets established for each of these goals:

- (1) Improved health status of the population
- (2) Improved community nutritional status

- (3) Increased financial protection
- (4) Increased equity in health services

In order to achieve these goals and targets, the *RPJMN III* outlines 13 policy directions:

- (1) Increase the access and quality of health services for mothers, children, adolescents and the ageing.
- (2) Increase the access to and even coverage of quality family planning services
- (3) Increase the access to community nutrition services
- (4) Increase communicable disease control and environmental health
- (5) Increase access to quality basic health services.
- (6) Increase access to quality referral services
- (7) Increase the supply, distribution and quality of human resources for health
- (8) Increase the supply, coverage, equal distribution of quality pharmaceutical and medical equipment
- (9) Increase the control of drugs and food
- (10) Increase health promotion and community participation
- (11) Strengthen management, research and development and health information
- (12) Develop and increase the effectiveness of health financing
- (13) Develop national health insurance

In coordination with *BAPPENAS*, the Ministry of Health has developed its own plans for both the long-term plan (2005–2025) and the period of the *RPJMN III*. The overall direction of the Ministry of Health's plans is to move its services and programmes from curative and rehabilitative to promotive and preventive. During this period, the access to health services and programmes would increase, as well as the quality of these. Based on the targets established in the *RPJMN III*, the Ministry of Health is developing its own strategic plan called the *RENSTRA* covering the five-year period 2015–2019, setting out more detailed plans and targets for the period.

Challenges for the Strategic Agenda of the Country Cooperation Strategy

In order to summarize the health situation analysis and the related policies and strategies, eleven priority areas for work are outlined below. These challenges reflect the current situation in Indonesia's health sector and the actions that are needed to improve health in Indonesia. These will be the basis for developing the Strategic Agenda of the Country Cooperation Strategy in the section below.

1. Communicable diseases

- ◉ Reduce the incidence of communicable diseases, especially TB, HIV/AIDS, malaria and those targeted for eradication or elimination – improving the technical quality and efficiency of programmes with emphasis on ensuring the sustainability of disease programmes and the integration with health services.
- ◉ Strengthen the immunization programme – maintaining polio-free status and achieving measles elimination and control of rubella and congenital rubella syndrome with emphasis on strengthening the routine immunization program and coverage in remote areas.

2. Noncommunicable diseases, nutrition, mental health and injuries

- ◉ Strengthen the responses to achieve targets in noncommunicable diseases, mental health and injuries – increasing the monitoring of key diseases and their risk factors, especially tobacco use, unhealthy diet, and physical inactivity emphasizing prevention through interventions to reduce risks and to ensure better control of noncommunicable disease at the primary care level.
- ◉ Nutrition – Ensure that effective nutrition interventions are integrated into programmes related to maternal, child and adolescent health, as well as to improve dietary practices related to noncommunicable diseases, especially diabetes and cardiovascular diseases.

3. Maternal, neonatal, child and adolescent health

- ◉ Reduce maternal and neonatal mortality – emphasizing good nutrition throughout pregnancy and increasing the accessibility and quality of services at facilities with basic emergency obstetric and newborn care (BEmONC) and comprehensive emergency obstetric and newborn care (CEmONC) especially in remote areas.
- ◉ Reduce infant and child mortality – emphasizing child health and nutritional status during the first two years of life, breastfeeding and health services for children especially in remote areas

4. Universal health coverage

- ◉ Promote universal health coverage and financial protection from catastrophic expenditures through efficient insurance schemes – emphasizing the difficulties of serving the poor and population in remote areas.
- ◉ Strengthen and rationalize the role of the private sector in delivering health services – encouraging an expanded role of the private sector as an efficient complement to public services and supporting national health policies

and programmes, with special attention to the conflict of interest of health personnel who work in both the public and private sector.

- ◉ Increase the number and quality of essential health personnel – emphasizing the production of additional staff and the in-service training of existing health workers with special attention to promote the distribution of health personnel to underserved, remote areas.
- ◉ Strengthen the roles of the district with support from the provincial and central levels in the efficient management of health services – emphasizing improved management of health services using performance assessments; strengthening the roles of the province in supporting district health services through assessments and training; supporting the roles of the central level in guiding policies and innovations in the health sector; ensure that additional central funds for the health sector are allocated to poor and remote districts with priority on public health interventions and staffing.

5. Preparedness and response to public health emergencies and disasters

- ◉ Strengthen disease surveillance systems – emphasizing the capacity for timely detection of disease outbreaks and appropriate responses at the early stages of outbreaks
- ◉ Prepare for health emergencies – emphasizing preparedness for emergencies and community resilience based on risks of natural disasters and ensuring effective surveillance and rapid response to disease outbreaks, fully implementing IHR (2005).

References

- (1) Badan Penelitian dan Pengembangan Kesehatan, Kementerian Kesehatan RI. (2013). *Riset Kesehatan Dasar (RISKESDAS)*. Jakarta, Indonesia: Kementerian Kesehatan RI.
- (2) Badan Penelitian dan Pengembangan Kesehatan, Kementrian Kesehatan. (2012). *Kajian Determinan Kematian Maternal di Lima Region*. Jakarta: Badan Penelitian dan Pengembangan Kesehatan.
- (3) BAPPENAS, National Development Planning Agency. (2012). *Report on the Achievement of Millennium Development Goals in Indonesia 2011*. Jakarta: Bappenas, National Development Planning Agency.
- (4) Indonesia Health Sector Review. (2012). : *Indonesia: Facing up to the Double Burden of Malnutrition*. Washington, DC: The World Bank.
- (5) Institute for Health Metrics and Evaluation. (2013). *Global Burden of Disease Profile: Indonesia*. Seattle, Washington: www.healthmetricsandevaluation.org.
- (6) Joint Committee on Reducing Maternal and Neonatal Mortality in Indonesia. (2013). *Reducing Maternal and Neonatal Mortality in Indonesia*. Washington, DC: The National Academies Press.
- (7) Kementerian Kesehatan RI. (n.d.). *Data Rumah Sakit Online*. Retrieved June 19, 2014, from Ministry of Health, Indonesia: http://202.70.136.52/rsonline/report/report_by_catrs.php

- (8) Michael J. Dibley, Christiana R. Titaley, et al. (2012). Iron and folic acid supplements in pregnancy improve child survival in Indonesia. *American Journal of Clinical Nutrition*, 95:220-30.
- (9) Pandu Harimurti, E. P. (2013). *UNICO Studies Series 8: The Nuts & Bolts of Jamkesmas, Indonesia's Government-Financed Health Coverage Program for the Poor and Near-Poor*. Washington, DC: The World Bank.
- (10) Robert E. Black, C. G. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet*, 427-451.
- (11) Statistics Indonesia (Badan Pusat Statistik—BPS), National Population and Family Planning Board (BKKBN). (2013). *Indonesia Demographic and Health Survey 2012*. Jakarta, Indonesia: BPS, BKKBN, Kemenkes, and ICF International.
- (12) The World Bank. (2008). *Health Public Expenditure Review 2008 - Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending*. Jakarta, Indonesia: The World Bank.
- (13) UNICEF-WHO-The World Bank. (2012). *Levels & Trends in Child Malnutrition: Joint Child Malnutrition Estimates*. New York: UNICEF-WHO-The World Bank.
- (14) World Health Organization. (2013). *World Malaria Report 2013*. Geneva: World Health Organization.
- (15) World Health Organization. (2010). *The Landscape Analysis: Indonesia Country Assessment*. World Health Organization.
- (16) World Health Organization. (2014). *Indonesia, Noncommunicable Diseases (NCD) Country Profiles*. Geneva: World Health Organization.
- (17) World Health Organization. (2014). *World Health Statistics 2014*. Geneva, Switzerland: WHO Press.
- (18) World Health Organization. (No. 35, 2013, 88). Global leprosy: update on the 2012 situation. *Weekly epidemiology record*, 365–380.

Chapter 3

Development Cooperation and Partnerships

As a recently-classified lower-middle-income country (LMIC) with a per capita income of about \$3500 per year, Indonesia's partnerships in the health sector have changed substantially. Most support for the health sector comes directly from the Indonesian Government and the private sector within the country. Health development partners support efforts to improve health through supplementary activities.

Development Banks

The development banks no longer have major health projects in the country, with the exception of the World Bank's project with the Ministry of Education for health professional education quality that closes at the end of 2014. Nonetheless, the World Bank has been active in sector work and analysis in the health sector and strongly supports efforts in social protection (especially Universal Health Coverage), HIV/AIDS, nutrition and food security, and decentralized programmes to eliminate poverty and improve the health of the community. Both the World Bank and the Asian Development Bank continue to provide loans for water supply and sanitation.

Bi-lateral Assistance for Health

The United States and Australia are the two major partners assisting the health sector. The Australian Government, through its Department of Foreign Affairs and Trade (DFAT), actively supports health projects emphasizing maternal and child health, HIV/AIDS, avian influenza and other infectious diseases, with large field projects in the province of Papua and Nusa Tenggara Timor (NTT). At the same time they have funded health sector work at the central level and were a major contributor to the Health Situation Analysis used as the basis for the Indonesia's Medium-term Development Plan for 2015–2019. They have supported WHO's work in the country, especially in the areas of avian influenza, strengthening the disease surveillance system, maternal health and water quality.

The United States government has been active in the health sector through several agencies including the US Agency for International Development (USAID), the Center for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and the Millennium Challenge Corporation (MCC). These agencies have traditionally supported efforts in disease control, especially HIV/AIDS, tuberculosis and disease surveillance. This support will continue but there has been an increasing interest in assisting with health conditions of the poor, especially maternal and child health, access and quality of health services. They are currently the largest contributor to WHO's work in Indonesia, especially in the areas of polio and other vaccine preventable diseases, acute respiratory infections, tuberculosis and more recently hospital accreditation to improve the quality of care.

International Agencies

Since 2003 the Global Fund for AIDS, tuberculosis and malaria (GFATM) has disbursed over half a billion US dollars to Indonesia and continues to provide extensive support for interventions, in about equal amounts, for these three diseases. While HIV/AIDS work is implemented by a number of government and civil society organizations, most support for tuberculosis and malaria are channeled directly to the Ministry of Health. The Global Fund works closely with WHO and has provided direct support to WHO for technical support in HIV/AIDS programmes. The GAVI Partnership has also provides extensive support for various immunization programmes and has recently funded the local production and introduction of a pentavalent vaccine that include *Haemophilus influenzae* type b (Hib) vaccine.

United Nations

Support to Indonesia is planned and coordinated through the UN Partnership for Development Framework (UNPDF), which is equivalent to the UNDAF (UN Development Assistance Framework) in other countries. This is to emphasize that UN agencies are partners with the Government rather than providing development assistance, especially since Indonesia is now a LMIC. The current UNPDF covers the period 2011–2015 and has the following three objectives: (1) Enhance EQUITY in access to benefits, services, and economic opportunities for improved, sustainable, productive and decent livelihoods; (2) Promote effective PARTICIPATION and protect the rights of the poor and vulnerable; and (3) Strengthen national and local RESILIENCE to climate change, threats, shocks and disasters. Special emphasis is given to the Millennium Development Goals (MDGs). Plans are underway to develop the next UNPDF covering the period 2015–2019 after the finalization of the government's medium-term development plan (*RPJMN 2015–2019*) in the last quarter of 2014. WHO's Country Cooperation Strategy 2014–2019 will serve as an input to this document.

Routine coordination among UN agencies is carried out through the UN Country Team (UNCT) consisting of the heads of all the UN agencies under the leadership of the Resident Coordinator. For technical issues, WHO's closest partners are UNICEF, UNFPA and UNAIDS. UNICEF has been working with a number of issues especially those related to the MDGs. They have worked jointly with WHO on maternal health, child health including the integrated management of childhood illnesses (IMCI), nutrition and expanded programme of immunizations (EPI). WHO and UNFPA have worked together on maternal and reproductive health, HIV/AIDS and adolescent health. They rely on WHO to provide special support for quality of reproductive health services and financial protection to ensure access to obstetrical services. UNAIDS has coordinated with UN Agencies including WHO and worked closely with National AIDS Commission and National AIDS Programme of the Ministry of Health to increase access of antiretroviral drugs to HIV infected and AIDS patients. The programme on Zero Infections, Zero Deaths and Zero Discrimination has been promoted in several high endemic areas.

Coordination

The Indonesian Government coordinates its health partners through the Centre for International Cooperation that is under the Ministry of Health's Secretary General but is led by an official from the Ministry of Foreign Affairs. The work of all international agencies and organizations are reviewed by this unit and its staff members normally attend key WHO meetings. In addition, the Bureau of Planning, also under the Secretary General, is often involved in issues of health planning in relation to the work of international organizations including WHO.

In discussions with WHO partners, several of these partners commented positively on the H4Plus group of key partners involved in maternal and neonatal health. At present this group consists of WHO, UNICEF, UNFPA and UNAIDS with additional participation by the World Bank and UNDP. This group discusses common interests and issues involving their work in maternal and neonatal health in order to facilitate coordination among these key partners. Additional coordination and exchange of information is also facilitated by occasional meetings among key health partners including both key UN and bilateral agencies.

Special attention must also be given to coordination of WHO work with government agencies outside the Ministry of Health. For example, the Ministry of Education is involved in the pre-service training of all health professionals. Issues such as tobacco control, road safety and environmental health usually involve agencies and organizations outside health. WHO also works closely with non-governmental and civil society organizations when there are common interests.

Overall, while international partners in the health sector play a relatively minor role in the overall health programmes of Indonesia, they provide key technical advice and programme innovations vital to the overall progress in health sector development. The key mechanisms for coordinating the work of these partners rest with the Ministry of Health, as well as the National Development Planning Agency (BAPPENAS) and the Ministry of Foreign Affairs.

Chapter 4

Review of WHO cooperation over the past CCS cycle

The current Country Cooperation Strategy (CCS) was developed in 2007 and was meant to cover the period 2007–2011. However, largely because of major changes in the economic, political and health situation in the country, the Strategic Agenda of this CCS was revised in 2010 to cover the period through 2013. The amended Strategic Agenda was officially finalized and sent to the Minister of Health in October 2010. Since the revised CCS was not released until 2010, this review will concentrate on two WHO biennial periods: 2010–2011 and 2012–2013, with some look ahead to the plans for the 2014–2015 biennium. The review looks at the major achievements of WHO during this period as listed by the professional staff members in the office. In addition, various plans and expenditures during this period were analyzed, including the sources of funds that supported WHO activities in the country. Finally, the current staff composition of the WHO Country Office (as of June 2014) was analyzed to represent professional staff involvement during the CCS period.

The major Strategic Agenda Priority Areas were as follows:

- (1) Health systems
- (2) Communicable disease
- (3) Women, children and adolescents
- (4) Noncommunicable diseases, mental health and the environment
- (5) Emergency preparedness and response
- (6) Partnerships and coordination

Financial information involved planned, awarded, and implemented amounts for each biennium. The achievements of WHO during this period were listed by the current WHO office staff, often using the end-of-biennium reports submitted to the WHO Regional Office and headquarters.

Financial implementation of the Strategic Agenda

Funding for various activities related to the Strategic Agenda were a major factor in the ability to achieve the results planned. WHO has two sources of funds to support these activities: Assessed Contributions (AC) provided by WHO Member States and which can be used for any planned expenditure for activities and staff, as well as for offices costs and administration. In recent years, much of the financial support for WHO activities and staff has come from donors in the form of Voluntary Contributions (VC), usually tied to specific projects with their own budgets and implementation schedules.

Figure 4.1: Total planned and implemented amounts (USD) for the WHO Indonesia Country Office

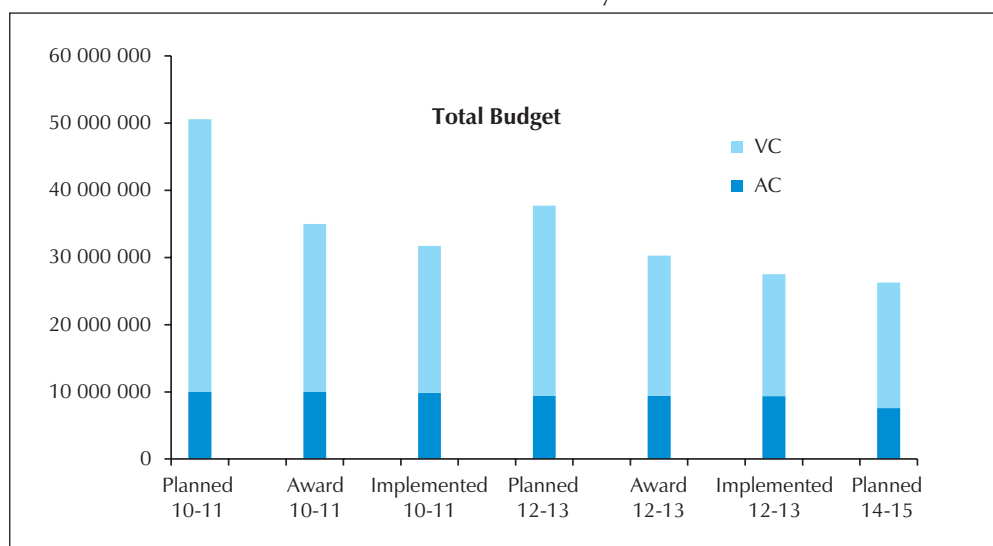


Figure 4.1 shows the total amount of funds for the Indonesia Country Office from 2010. In 2010, the planned amount for the biennium was about US\$ 50 million, 80% from VC funds, although the amount available (awarded) by the end of the biennium was only about US\$ 35 million. In the previous two biennia, the total amount of AC funding was about US\$ 10 million for each biennium or US\$ 5 million per year. However, the planned amount of AC funding was reduced in the 2014–2015 biennium to about US\$ 7.6 million, to reflect the 20% of global AC funds that are withheld by headquarters to be released to the Regions in 2015.

VC funding was planned for about US\$ 40 million in the 2010–2011 biennium but the amount actually funded was about US\$25 million. Following that, the planned amount of VC funding for the 2012–2013 biennium was reduced to about US\$ 29 million with about US\$ 21 million received. Therefore, plans for the 2014–2015 biennium were slightly less than US\$ 20 million. Overall, the total amount of funds available dropped from about US\$ 35 million in 2010–2011 to US\$30 million in

2012–2013 and is likely to fall further to about US\$ 25 million in 2014-2015, based on a planned amount of US\$ 26.3 million for the 2014–2015 biennium. Overall, this is a significant reduction in financial resources from 2010 until the present.

Figure 4.2: Total Expenditures (USD) by CCS Strategic Agenda Priority Areas (2010–2013)

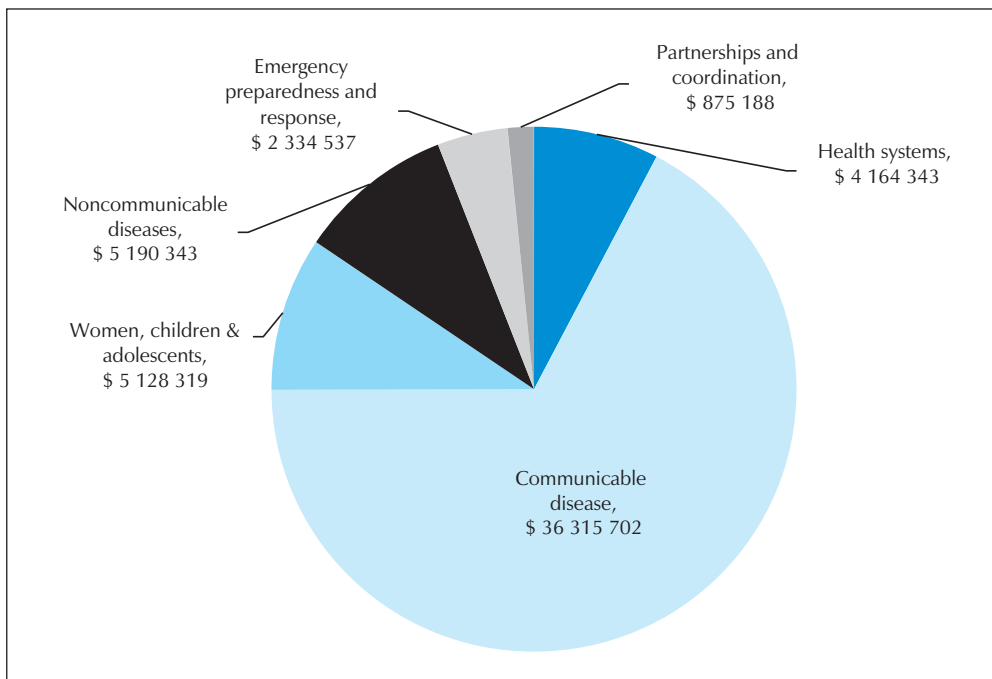
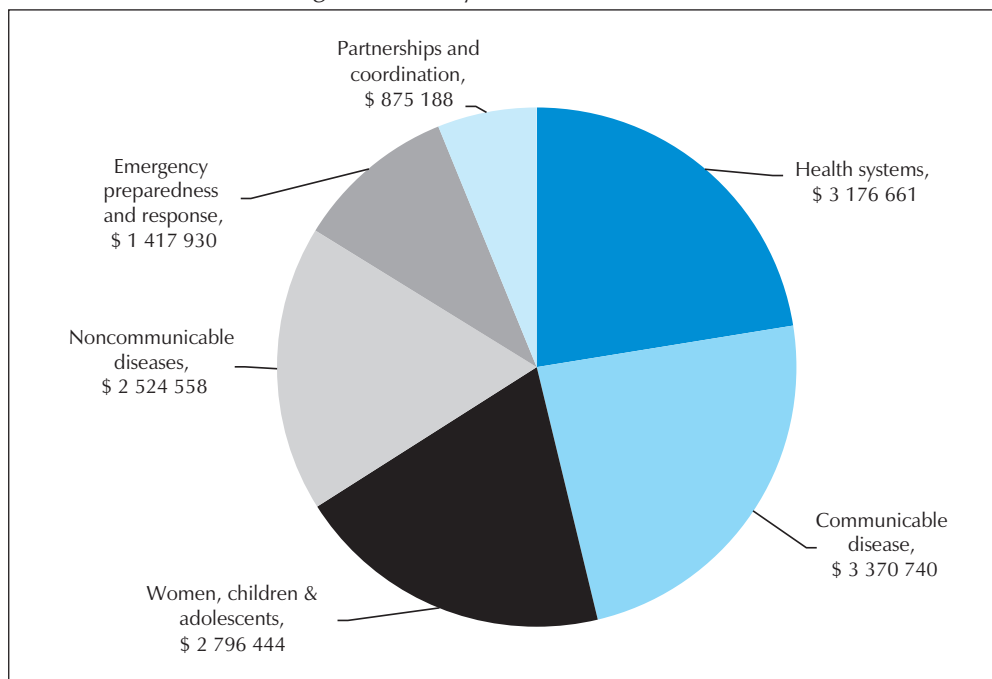


Figure 4.2 shows the total amount of expenditures during the period 2010–2013 by CCS Strategic Agenda Priority Areas. Two thirds of expenditures were for the communicable disease Strategic Agenda whereas Women, children and adolescents and Noncommunicable diseases represented about 10% of total expenditures. Health systems was about 8% of the total and emergencies about 4%.

During the four year period covering the 2010–2011 and 2012–2013 biennia, about US\$ 14.2 million of AC funding was used to support activities for CCS Strategic Agenda Priority Areas, with another US\$ 5 million used for office and administrative costs. Figure 4.3 shows that similar amounts were used to fund the following four Priority Areas: Health systems, Communicable diseases, Women, children and adolescents, and Noncommunicable diseases, mental health and the environment. Partnerships and Emergencies used lower amounts of AC funding.

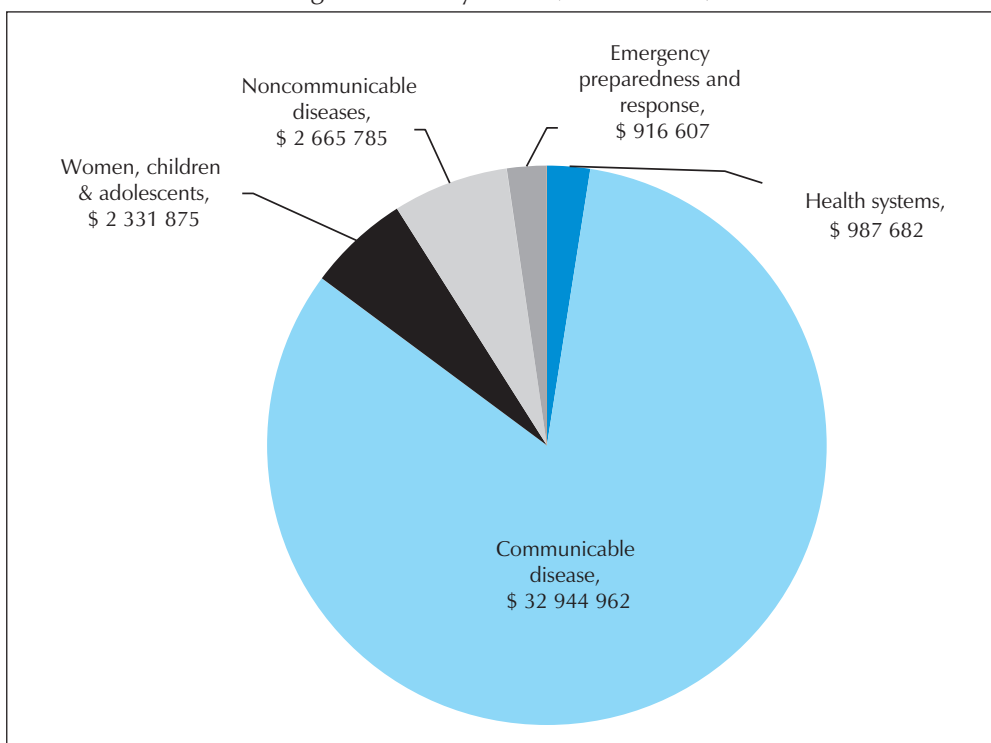
Figure 4.3: Expenditures (USD) of Assessed Contributions (AC) by CCS Strategic Agenda Priority Areas (2010–2013)



The picture of expenditures for Voluntary Contributions is considerably different as shown in Figure 4.4. Of the \$39.8 million expended on programmes and activities during these four years, \$32.9 million (or about 83%) was for communicable disease programmes. Women, children and adolescents and noncommunicable diseases, mental health and the environment each received between US\$ 2 and US \$ 3 million for staff and activities. The majority of VC funding for noncommunicable diseases was for activities related to the Tobacco Free Initiative. Health systems and Emergencies used slightly less than US\$ 1 million of VC funding each during this period. Clearly, the Communicable disease programmes of the WHO Country Office received the major share of donor-supported funding during the period of CCS implementation.

During the period of the CCS, partner support for VC funding of projects was a major driver of the budgets for the various Priority Areas of the CCS Strategic Agenda. From 2010 to 2013, 83% of VC expenditures were for Communicable disease programmes, with some shifts in funding among these programmes. In the meantime, the limited amount of AC funding has sustained other agenda areas, but with a drop in total AC funding in 2014–15, these programmes are likely to be under increasing pressure for financial support. Health systems and Maternal, child and adolescent health have been able to obtain some support from partners, while noncommunicable diseases, mental health and the environment have seen drastic decreases in funding over the last five years.

Figure 4.4: Expenditures (USD) of Voluntary Contributions (VC) by CCS Strategic Agenda Priority Areas (2010–2013)



Professional Staff in the Country Office

The numbers and types of professional staff in the WHO Country reflect both the priorities of work during this period and the funding available to hire staff. There are currently three types of professional staff members working in the office: (1) international staff, some of whom are long-term WHO staff members and others are short-term hires, sometimes for multiple contracts; (2) national professional officers (NPO) and temporary national professionals (TNP) who are Indonesian nationals hired as WHO staff members in the country; and (3) special service agreements (SSA) for Indonesian nationals who are not WHO employees but work under special contracts, usually for less than a year but often renewed. (The number of SSA contracts is gradually being reduced and phased out.)

Table 4.1: Summary of the number of professional staff members by CCS Strategic Agenda

Country cooperation strategic agenda	Number of Professional Staff Members				
	International		National professional and special services		Total
	Occupied	vacant	Occupied	vacant	
1. Health policy and system development	2	0	4	1	7
2. Prevention and control of communicable diseases	6	1	25	5	37
3. Health of women, children and adolescents	1	0	4	0	5
4. Noncommunicable diseases, mental health, health and environment	2	0	4	2	8
5. Emergency preparedness and response	0	0	1	1	2
6. Partnerships, coordination and WHO's presence in countries	3	0	2	0	5
Total	13	1	40	9	64

Table 4.1 shows that there are currently 64 professional staff positions, some of which are temporary, in the Country Office. One international and nine national positions are currently vacant, meaning that there are 54 active professional staff members. Seven international and 30 national positions are in the area of communicable disease, representing 57% of all professional positions in the office. Ten of these positions are working in tuberculosis programmes, eight each are for HIV/AIDS and surveillance, and seven are in vaccine-preventable diseases and polio.

The other Strategic Agenda Priority Areas have similar staff patterns with one or two international positions and four to six national positions. It should be noted that two international staff positions in health financing and the Tobacco Free Initiative are supported by the WHO Regional Office and headquarters, not the Country Office's budget, and one position is a seconded staff member from US-CDC. Noncommunicable disease, mental health and the environment currently have two out of eight positions that are vacant and Emergency and response has only three positions, currently two of which are vacant.

Partnerships and coordination

During this period, WHO and office staff members worked closely with health partners in Indonesia, both multilateral and bilateral. WHO played an active role in the United Nations Country Team (UNCT) made up of the heads of all UN agencies. Coordination of UN agencies was facilitated by the joint development of the United Nations Partnership for Development Framework (UNPDF). On the technical level, WHO worked with other UN agencies, especially UNICEF and UNFPA, on several joint activities related to maternal, child and adolescent health and with UNAIDS on HIV/AIDS programmes. H4Plus is a health group in Indonesia of UN agencies (WHO, UNICEF, UNFPA, UNAIDS, World Bank and UNDP) that meets on a regular basis to discuss maternal and neonatal health issues. Under EMPOWER, IOM, UNFPA and WHO have worked with the government to support the implementation of the national law, policies, and action plans to combat human trafficking, as well as the protection and empowerment of victims. WHO is also involved with UNFPA and the International Organization for Migration (IOM) in a project from the UN Partnership to promote the Rights of Persons with Disabilities Multi-Donor Trust Fund (UNPRPD MDTF) in Jakarta.

By far the two bilateral partners who have worked most closely with WHO in Indonesia are USAID/CDC and Australia's Department of Foreign Affairs and Trade (DFAT). USAID and CDC have supported activities and staff in several communicable disease programmes as well smaller amounts of funding for health systems and maternal and child health. DFAT played a major role in supporting activities related to avian influenza and has recently supported health systems work in the country. Other bilateral partners providing support include Norway, which funded emergency assistance through WHO, and GTZ which supported the MOH for health systems work completing its project in 2012. The European Union also provided major support related to avian influenza. WHO has worked closely with multilateral agencies such as the GAVI Alliance, the Global Fund for AIDS, TB and Malaria and the Gates Foundation in communicable diseases. The Bloomberg Foundation and the World Lung Foundation have provided support for tobacco control programmes and the TB programme has been supported by USAID through the joint TBCARE programme with other partners such as KNCV and the Tuberculosis Foundation. Drug companies, such as Novartis and Glaxo Smith Kline, have provided various drugs for communicable disease programmes such as Mass Drug Administration for filariasis.

Besides receiving support from the above health partners, WHO has maintained continuous dialogues with key health partners regarding major policy issues of common interest. WHO's large professional staff at the Country Office has been a resource for partners needing information regarding technical programmes and local developments in health.

Conclusions

During the period of Indonesia's Country Cooperation Strategy (CCS), almost all Priority Areas of the Strategic Agenda were covered, as evaluated by responsible staff members. This represents a wide range of health topics that contributed to efforts to improve health in Indonesia. It can be stated that all areas of the Strategic Agenda have been covered during the CCS period. However, financial resources for these activities were clearly the major factor in determining the scale of activities and staffing for each of the Priority Area of the Strategic Agenda. Since Voluntary Contributions funded over two thirds of the resources through the period 2010–2013, the involvement of partners was a key factor guiding the work of WHO at the country level. Partner support for communicable disease programmes reflects this with over half of the WHO professional staff and 83% of VC funding used for these programmes. The scope and intensity of other Priority Areas of the Strategic Agenda during the CCS period were limited in comparison.

Another key issues resulting for the analysis here is the changing picture of financing of WHO staff and activities in Indonesia over the CCS period and into the current 2014–2015 biennium. Total planned costs for staff and activities in 2014-2015 are expected to drop from US\$ 37.7 to US\$ 26.3 million, or about 30%, compared with the 2012–2013 biennium. Even the funding for communicable disease programmes is being reduced substantially, especially in surveillance and epidemic response and polio eradication. This reflects not only the changing interests of WHO health partners, but also the increased capacity of the Ministry of Health in dealing with communicable diseases and emergency preparedness and response. Indonesia expects to develop core capacities required for implementing IHR (2005) by 2014. At the same time, Indonesia is experiencing new health challenges, especially in ensuring Universal Health Coverage and the increasing noncommunicable disease burden. All these changes should be considered in guiding WHO's work in the future.

Chapter 5

The Strategic Agenda for WHO Cooperation

The Strategic Agenda describes the focus for WHO work in Indonesia for the period 2014 to 2019, consisting of five Strategic Priorities and some cross-cutting issues of work supporting multiple Strategic Priorities. While the Strategic Agenda outlines the set of priorities for work affecting the financial and technical resources planned for the Country Office, other technical areas may be considered for the Country Office's work during the CCS period. WHO's resources from all levels are able to respond to requests for technical information and support in all health topics as needed. However, effort and resources would be minimal compared to those used for the priorities of the Strategic Agenda.

Strategic Priorities

The following outlines the five **Strategic Priorities** for WHO work in Indonesia. Each of these priorities has up to four **Main Focus Areas** showing what WHO expects to accomplish related to the Strategic Priority. Within each Main Focus Area are up to four **Strategic Approaches** describing how WHO intends to achieve that Main Focus Area.

Strategic Priority 1: Address the challenges of communicable diseases and reach the 'Post 2015 Agenda' targets

- 1.1 Main Focus Area:** The un-finished MDG 6 HIV targets and control of hepatitis and sexually transmitted infections (STIs)
- ◉ **Strategic Approach 1.1.1:** Promote expansion of quality HIV, STIs and hepatitis prevention and treatment services with particular focus on key populations within the framework of Universal Health Coverage
 - ◉ **Strategic Approach 1.1.2:** Support expansion of sustainable, decentralized and integrated service delivery models for HIV, STIs and hepatitis with strong community participation and address the prevention and care treatment cascade

- ◉ **Strategic Approach 1.1.3:** Promote the effective use of implementation research and generation of quality strategic information to inform programmes including surveillance, programme reporting and evaluation

1.2 **Main Focus Area:** Implementation of Post 2015 Tuberculosis Strategy

- ◉ **Strategic Approach 1.2.1:** Support INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION focusing on early diagnosis of tuberculosis (including drug-resistant tuberculosis) screening of contacts and high-risk groups, and patient supported treatment of all types of tuberculosis
- ◉ **Strategic Approach 1.2.2:** Promote BOLD POLICIES AND SUPPORTIVE SYSTEMS in line with UHC, strengthen regulatory frameworks, political commitment with adequate resources, address underlying social determinants, engage with Civil Society Organizations and promote partnerships
- ◉ **Strategic Approach 1.2.3:** Support INTENSIFIED RESEARCH AND INNOVATION encouraging investments in research, discovery, development and the rapid uptake of new tools, interventions and strategies to optimize implementation and impact

1.3 **Main Focus Area:** A decentralized and effective system for elimination of malaria, other vector borne diseases (VBDs), and neglected tropical diseases (NTDs)

- ◉ **Strategic Approach 1.3.1:** Intensify surveillance for malaria and neglected tropical diseases and target effective interventions to reduce the incidence of these diseases
- ◉ **Strategic Approach 1.3.2:** Reduce transmission of malaria and other VBDs through improved vector management
- ◉ **Strategic Approach 1.3.3:** Monitor drug efficacy monitoring and screen for glucose-6-phosphate dehydrogenase (G6PD) deficiency
- ◉ **Strategic Approach 1.3.4:** With the support of partners, work toward the elimination of NTDs through the effective implementation of integrated campaigns with high population coverage in targeted geographic areas

1.4 **Main Focus Area:** Intensified vaccine coverage and the introduction of new vaccines

- ◉ **Strategic Approach 1.4.1:** Advocate policies that prioritize cost-effective prevention measures such as immunizations and expand partnerships to dramatically increase revenues to support immunization within Indonesia
- ◉ **Strategic Approach 1.4.2:** Increase community demand for immunizations with effective health promotion

- ◉ **Strategic Approach 1.4.3:** Strengthen and use immunization services data at the individual and facility levels to increase coverage
- ◉ **Strategic Approach 1.4.4:** Strengthen vaccine preventable disease surveillance systems for measles, rubella/congenital rubella syndrome (CRS), HPV (Human Papilloma Virus), encephalitis/meningitis, diphtheria, polio, and rotavirus

Strategic Priority 2: Address the challenge of noncommunicable diseases and their modifiable risk factors

2.1 Main Focus Area: Development and implementation of appropriate policy frameworks for the prevention and control of major noncommunicable diseases (NCDs)

- ◉ **Strategic Approach 2.1.1:** Secure the highest level of commitment from relevant government agencies, such as the ministries of health, planning, social welfare, education, environment and others to act on NCDs and the key risk factors on NCDs
- ◉ **Strategic Approach 2.1.2:** Update national multisectoral policies to include appropriate, best and good-buy NCD interventions
- ◉ **Strategic Approach 2.1.3:** Build and sustain partnerships for high-level policy advocacy with all stakeholders including non-governmental organizations (such as professional associations) and the private sector
- ◉ **Strategic Approach 2.1.4:** Strengthen institutional capacity within the MoH to develop programmes, mobilize resources, build partnerships, and monitor implementation

2.2 Main Focus Area: Exposure of the population and individuals to the shared biological, dietary and environmental risk factors associated with NCDs

- ◉ **Strategic Approach 2.2.1:** Develop and implement policies to implement high-level measures to reduce tobacco use and salt, sugar and fat intakes including ratification of the WHO Framework Convention on Tobacco Control (WHO-FCTC)
- ◉ **Strategic Approach 2.2.2:** Promote, through community initiatives and population-wide campaigns, healthy lifestyle and behavioral changes to modify unhealthy diets and increase physical activity

- ◉ **Strategic Approach 2.2.3:** Promote lifestyle modifications for individuals at risk or with known risk factors for developing NCDs including through use of innovative approaches such as mobile technology
- ◉ **Strategic Approach 2.2.4:** Strengthen the health impact assessment process to minimize human exposure to adverse environmental pollutants and conditions
- ◉ **Strategic Approach 2.2.5:** Promote and address nutrition issues through life cycle approach starting from adolescent, pregnancy and in labour

2.3 **Main Focus Area:** Health system response to more effectively control and prevent NCDs

- ◉ **Strategic Approach 2.3.1:** Identify and address health system-related gaps that can undermine the implementation of NCD prevention and control interventions
- ◉ **Strategic Approach 2.3.2:** Build the capacity of healthcare providers to better manage NCDs and their risk factors
- ◉ **Strategic Approach 2.3.3:** Adapt and implement the Package of Essential Noncommunicable Disease (PEN) interventions for Primary Health Care in low-resource settings
- ◉ **Strategic Approach 2.3.4:** Improve secondary prevention through better management of NCD metabolic risk factors

2.4 **Main Focus Area:** Monitoring, evaluation and research to determine trends in NCDs and their risk factors as well as the effectiveness and impact of interventions

- ◉ **Strategic Approach 2.4.1:** Support the development of national indicators and voluntary targets to monitor trends and determinants of NCDs prevention and control
- ◉ **Strategic Approach 2.4.2:** Support surveillance activities built upon existing surveillance tools and frameworks
- ◉ **Strategic Approach 2.4.3:** integrate NCD indicators into national surveys and health research priorities
- ◉ **Strategic Approach 2.4.4:** Improve the quality and use of existing health information systems and cancer registries to support surveillance activities

Strategic Priority 3: Improve maternal, neonatal, child and adolescent health through increasing access to quality services

3.1 **Main Focus Area:** Quality of care and patient safety for maternal, neonatal and child health (MNCH)

- ◉ **Strategic Approach 3.1.1:** Develop MNCH quality health care and patient safety strategy
- ◉ **Strategic Approach 3.1.2:** Standardize MNCH services and supervisory guidelines
- ◉ **Strategic Approach 3.1.3:** Build capacity to conduct MNCH implementation research
- ◉ **Strategic Approach 3.1.4:** Collaborate with other units to improve immunization, nutrition and other health issues related to MNCH

3.2 **Main Focus Area:** Human resource (HR) development and deployment for MNCH, especially in under-served and remote areas

- ◉ **Strategic Approach 3.2.1:** Standardize and improve public and private MNCH in-service and pre-service training
- ◉ **Strategic Approach 3.2.2:** Adapt HR strategies to meet competency and skill-mix requirements of providers and program managers for MNCH with special attention to remote and under-served areas
- ◉ **Strategic Approach 3.2.3:** Support the development of career paths to enhance the commitment of MNCH service providers
- ◉ **Strategic Approach 3.2.4:** Promote the deployment of support systems to improve work environments for MNCH

3.3 **Main Focus Area:** Financial access to MNCH services within comprehensive health financing systems

- ◉ **Strategic Approach 3.3.1:** Simplify financial streams for MNCH, in collaboration with health systems
- ◉ **Strategic Approach 3.3.2:** Establish financing governance systems and operational rules to ensure efficient use of funds for MNCH, in collaboration with health systems

3.4 **Main Focus Area:** Adolescent and reproductive health

- ◉ **Strategic Approach 3.4.1:** Advocate for adolescent health and the rights of adolescents
- ◉ **Strategic Approach 3.4.2:** Develop and update family planning guidelines, tools, and programme planning

- ◉ **Strategic Approach 3.4.3:** Conduct research to support adolescent and reproductive health
- ◉ **Strategic Approach 3.4.4:** Support the development and strengthening of adolescent health services including equitable access to quality reproductive health information and services

Strategic Priority 4: Ensure Indonesia achieves universal health coverage (UHC)

4.1 Main Focus Area: Coverage of quality health services with an emphasis on the poor and vulnerable, as well as the middle-class unaffiliated with current coverage schemes

- ◉ **Strategic Approach 4.1.1:** Investigate mechanisms to ensure that adequate health services reach the poor, especially in the informal sector, and advocate improvements and policies to increase coverage
- ◉ **Strategic Approach 4.1.2:** Strengthen institutional capacity for ensuring quality and safety of health care services, including accreditation systems and clinical governance, emphasizing services to the poor
- ◉ **Strategic Approach 4.1.3:** Undertake research to diagnose barriers and constraints to access to health services and advocate initiatives and policies to reduce these constraints
- ◉ **Strategic Approach 4.1.4:** Support government initiatives and policies for health sector reform

4.2 Main Focus Area: Preventive and promotive aspects of UHC

- ◉ **Strategic Approach 4.2.1:** Advocate for the inclusion of preventive and promotive health services as part of UHC and undertake research and analysis to measure the benefits
- ◉ **Strategic Approach 4.2.2:** Investigate initiatives and incentives for improved primary health care to control noncommunicable diseases such as hypertension and diabetes
- ◉ **Strategic Approach 4.2.3:** Identify and advocate how UHC might institute incentives to reduce key risk factors such as obesity and tobacco use
- ◉ **Strategic Approach 4.2.4:** Strengthen Primary care as gate keeper, to promote healthy life style, and early detection
- ◉ **Strategic Approach 4.2.5:** Capacity building for HRH (Human Resources for Health) especially in getting post graduate or PhD titles.

4.3 Main Focus Area: Monitoring health financing and expenditure to support health policies

- ◉ **Strategic Approach 4.3.1:** Strengthen the capacity to utilize the latest WHO tools for the system of health accounts (SHA)
- ◉ **Strategic Approach 4.3.2:** Investigate methods to collect and analyze health financing and expenditure data from the private sector
- ◉ **Strategic Approach 4.3.3:** Analyze health financing and expenditure data emphasizing the implications for policies and programmes and disseminate lessons from Indonesia and other countries to provide financial protection from healthcare costs
- ◉ **Strategic Approach 4.3.4:** Advocacy initiatives to increase the level of public health expenditure and improve the efficiency of health expenditures

4.4 Main Focus Area: UHC-related information systems and analysis to improve its implementation

- ◉ **Strategic Approach 4.4.1:** Develop and test simple indicators of coverage appropriate for the district level and establish ways to use these indicators
- ◉ **Strategic Approach 4.4.2:** Investigate ways to monitor use of private sector health services and facilities
- ◉ **Strategic Approach 4.4.3:** Increase the utilization of human resources information from health facilities to improve staff deployment, especially in remote regions
- ◉ **Strategic Approach 4.4.4:** Support the government in health workforce planning and education inline with UHC needs

Strategic Priority 5: Enable capacity for preparedness and response to public health emergencies and disasters

5.1 Main Focus Area: Capacity to detect, verify, assess, inform and respond to public health events

- ◉ **Strategic Approach 5.1.1:** Develop and implement the action plan to maintain and operationalization of international health regulations (IHR) core capacities
- ◉ **Strategic Approach 5.1.2:** Evaluate and strengthen capacity to detect, verify and respond to the public health events

- ◉ **Strategic Approach 5.1.3:** Enhance coordination and collaboration across the sectors to detect, assess and respond
 - ◉ **Strategic Approach 5.1.4:** Develop capacity for risk assessment and risk communication of public events at the national and sub-national levels
- 5.2 **Main Focus Area:** Laboratory capacities and research for disease surveillance to promote evidence-based decision-making
 - ◉ **Strategic Approach 5.2.1:** Enhance quality improvements in laboratory diagnostics for emerging infectious diseases
 - ◉ **Strategic Approach 5.2.2:** Strengthen laboratory capacity for bio-safety and bio-security
 - ◉ **Strategic Approach 5.2.3:** Enhance research capacity and conduct researches for evidence-based decision-making for disease surveillance
 - ◉ **Strategic Approach 5.2.4:** Increase laboratory collaboration at the national and international levels in the area of human-animal interfaces
- 5.3 **Main Focus Area:** Emergency and disaster risk management for health
 - ◉ **Strategic Approach 5.3.1:** Review and revise the policies and strategies for emergency disaster risk management
 - ◉ **Strategic Approach 5.3.2:** Assess and strengthen the regional crisis centres for emergency and disaster risk management for health
 - ◉ **Strategic Approach 5.3.3:** Enhance information management and its application at the national and sub-national levels
 - ◉ **Strategic Approach 5.3.4:** Promote and conduct research on disaster risk reduction
- 5.4 **Main Focus Area:** Emergency preparedness and response
 - ◉ **Strategic Approach 5.4.1:** Develop and test all hazards emergency preparedness and response plans
 - ◉ **Strategic Approach 5.4.2:** Enhance the country capacity to apply the emergency response framework
 - ◉ **Strategic Approach 5.4.3:** Strengthen coordination and collaboration across sectors as a health cluster lead for emergencies and disasters
 - ◉ **Strategic Approach 5.4.4:** Enhance capacities of the rapid response and medical teams during emergencies and disasters

Cross-cutting work of WHO Categories

As set out in WHO's 12th General Programme of Work (GPW), the Organization's work is arranged by five **Categories**: (1) Communicable disease; (2) Noncommunicable diseases; (3) Health through the life course; (4) Health systems; and (5) Preparedness surveillance and response. Within each of these Categories are four to five **Programmes**, such as tuberculosis and HIV/AIDS programmes within the Communicable disease Category. All WHO budgets and workplans are arranged by these Categories. However, it is recognized that successful work in each Strategic Priority of the Strategic Agenda outlined above will require the involvement of multiple technical units from several Categories and Programmes. For example, the Strategic Priority for maternal and neonatal health is the overall responsibility of Category 3, Health through the life course. Other technical inputs are also needed from nutrition (Category 2), malaria (Category 1) and the distribution of drugs and equipment (Category 4). Table 5.1 lists similar relationships reflecting cross-cutting issues for all five Strategic Priorities.

Chapter 6

Implementing the Strategic Agenda: Implications for the entire Secretariat

The five Strategic Priorities included in the Strategic Agenda represent the major areas for work over the period from 2014–2019. While this does not exclude other work of WHO during this period, it is expected that most of the resources of the office will be used for these priorities. In order to make significant progress in these Strategic Priorities, the following should be considered.

1. Emphasis on technical support

Given that the Indonesian Government has the financial resources to implement health programmes and support the delivery of health services, the role of WHO should be technical in nature. This is appropriate for WHO since the Organization is a technical agency with limited funds for implementation. It also implies that the Country Office will have international and Indonesian staff members who are capable and technically qualified, with backup from the Regional Office and headquarters as needed. Therefore, the following activities will be supported in efforts to achieve the Strategic Agenda:

- **Technical standards and guidelines** – WHO is continually developing technical guidelines and standards for health programmes. As needed for Indonesia, these must be adapted and tested for local use. In addition, efforts by the WHO staff should involve field testing of these to ensure that they are applicable and useful for health programmes and services under field conditions in the country.
- **Advocacy** – WHO will advocate scientifically recognized policies and initiatives that are relevant to improving health in Indonesia. This can be strengthened by WHO governing bodies meetings such as the Regional Committee and the World Health Assembly.

- ◉ **Programme reviews** – WHO will support and participate in international technical and implementation reviews of programmes as requested by the Ministry of Health. If experts are not available in the Country Office, WHO will assist in recruiting experts from Indonesia or internationally.
- ◉ **Comparative information from other countries** – WHO will support the exchange of information about key health programmes and initiatives with countries similar to Indonesia by exchange visits or meetings.
- ◉ **Implementation research** – WHO will support small-scale research, especially at the field level, to identify key issues inhibiting implementation of programmes or to learn why programmes have been successful in some regions. Findings will then be presented for expansion to other areas.
- ◉ **Analysis of key health indicators and trends** – WHO will emphasize the analytical review of health information to determine trends useful for decision-making affecting health. This includes information about health budgets and expenditures.
- ◉ **Policies and strategy formulation and adjustments** – Based on analytical work, internationally accepted practices, and field research, WHO will assist the Government in formulating and adjusting policies related to key health programmes and initiatives.

2. Close involvement with the Ministry of Health and other agencies and organizations as necessary

Based on WHO's Constitution and the participation of the Ministry of Health in the Organization's governance, the Ministry is the major partner of WHO at the country level. Therefore, WHO staff members will work closely with Ministry of Health units to determine how WHO can most usefully support the work of the Ministry. Whenever possible, WHO will also help develop capacity within the Ministry in order to ensure the continual strengthening of the work of the Ministry. In addition, WHO will also work closely with other key ministries and organizations involved in health. For example, the Ministry of Education is involved with the training of health professional and the National Planning Agency (*BAPPENAS*) is responsible for overall planning and coordination within the Government. In some cases, WHO will work with non-governmental and civil society organizations actively involved in health initiatives, such as with HIV/AIDS programmes.

3. Decentralization of Health Services

All work of WHO to achieve the Strategic Agenda should consider the Government's initiatives to decentralize health services to the district level that started in 1999. With 34 provinces and 502 districts and municipalities, this represents a considerable challenge in ensuring that all health facilities and programmes are optimal. While new guidelines

and programmes can be developed at the central level, the issues of disseminating these to districts and training staff there require major efforts from the central and provincial levels. WHO will work with health staff at all levels to help define and support the roles of each administrative level to strengthen the health system.

4. Involvement across disciplines of the Country Office

One of the new aspects of this Country Cooperation Strategy is the initiative to promote the involvement of different technical areas in the Country Office as described in the Strategic Agenda and shown in the matrix in Table 5.1, arranged by Strategic Priority and the five technical Categories for WHO work. This matrix implies two ways of implementation. First, is work directly related to a Strategic Priority, such as the example of maternal and neonatal mortality, where the staff member responsible for maternal and child health is in charge of developing workplans involving other technical staff members such as nutrition, malaria and health systems. This lead staff member will also coordinate resource mobilization to ensure that all technical areas involved in the work have adequate funding to support efforts for the Strategic Priority.

The second type of joint efforts would be in technical areas such as vital registration systems that benefit several Strategic Priorities. Initiatives and work in these areas will be led and coordinated by the Category (matrix column in Table 5.1) responsible, in this case health systems. Workplans would be planned and implemented by the health systems manager consulting with staff members from the Strategic Priority areas with concerns for vital registration, ensuring that the work meets their needs. While it is easy to note involvement of several technical units in Strategic Priority work, implementation requires consistent efforts and attention to ensure that this cooperation occurs.

5. Adequate country presence

Considering the emphasis on technical roles of WHO, the Country Office requires technically qualified staff who are familiar with the conditions in Indonesia and can follow-up progress and manage efforts on the Strategic Priorities outlined here. Table 6.1 shows the current technical staff and positions in the Country Office. With a total of 57 technical staff positions in the Country Office, it is unlikely that there will be any increase in total positions and staff reductions may be required if additional resources are not mobilized. In some cases, technical tasks can be accomplished more efficiently by short-term national and international experts or temporary assignments from other levels of WHO. The terms of reference for current positions need to be reviewed to identify those that can be phased out or revised to meet the requirements for work on the new Strategic Agenda. In estimating the technical staff requirements, work for both the Strategic Priorities and the cross-cutting issues (the column in the matrix), such as the example of vital registration, need to be considered. The discussion below will cover each of the WHO Categories to capture both the needs to achieve Strategic Priorities as well as the cross-cutting issues in the Strategic Agenda.

- ◉ **Communicable diseases** – As discussed in the review of the previous CCS, WHO Country Office activities in communicable disease programmes have been extensive. Current staff positions in this area represent over half of all positions in the office. For the CCS 2014–2019, it is expected that communicable disease programmes will continue, although some field activities may be reduced. Therefore, there may be a reduction in the number of positions.
- ◉ **Noncommunicable diseases** – Work in this area is expected to expand in the CCS 2014–2019 period with major efforts in the NCD Strategic Priority as well as for nutrition involved in at least three Strategic Priorities. There are currently nine professional positions in the NCD areas and an increase in the staff members here will depend on the availability of additional resources. Based on this CCS, it is likely that the current terms of reference for NCD area positions will be revised in line with the required work for the Strategic Agenda.

Table 6.1: Current Number of Professional Staff Members by Strategic Priorities

Strategic Priorities	Number of Professional Staff Members				
	International		National professional and special services		Total
	Occupied	vacant	Occupied	vacant	
1. Address the challenges of Communicable Diseases and reach the 'Post 2015 Agenda' targets	5	0	20	4	29
2. Address the challenge of noncommunicable diseases and their modifiable risk factors	2	0	5	2	9
3. Maternal, newborn and child health (MNCH) through improving access to MNCH quality of care	1	0	3	0	4
4. Ensure Indonesia achieves Universal Health Coverage	1	1	4	1	7
5. Enabling capacity for preparedness and response to public health emergencies and disasters	2	0	4	2	8
Total	11	1	36	9	57

- ◉ **Promoting health through the life course** – Since maternal, neonatal and child health is a key Strategic Priority and also a major Government objective for the coming medium-term development plan, it is expected that staffing in the office will increase from the current level of four positions if additional resources are mobilized for activities in this area.
- ◉ **Health systems** – Given the Government’s priority for universal health coverage, additional Country Office staff members will be required to ensure WHO’s active contribution. This includes a full-time international expert in the area of health financing or at least senior national professionals. In addition, other areas of health systems are important to support work for several Strategic Priorities, including the vital registration system, logistics for medicines and supplies, information systems and especially human resources for health. The terms of references for the seven existing staff positions need to be reviewed in light of the Strategic Agenda.
- ◉ **Preparedness, surveillance and response** – There are two aspects of work in this Category. The first is preparedness and capacity building for both disease outbreaks and natural disasters, requiring adequate full-time staff in the Country Office. The second aspect involves health emergencies and disasters that may occur during the CCS period. Required staff members can be recruited based on the needs of the crisis, although the office should have the capacity to coordinate emergency efforts. The current terms of references for existing positions will be reviewed in light of the Strategic Agenda to ensure adequate support from the Country Office staff members for both aspects of this Category, depending on the mobilization of additional funding.

6. Support from the South-East Asian Region, other Regions and headquarters

It is likely that there will be specific activities where the WHO Regional Office and headquarters can make significant contributions to work on the Strategic Agenda. In the past, communicable disease programmes have benefited from Regional Office support, especially in programme reviews and resource mobilization. Headquarters has provided assistance for health financing by assigning a part-time staff member and assisting with technical support visits. Hospital accreditation activities have also been supported by headquarters. In the CCS 2014–2019, this continued support is needed and it is expected that staff members can be assigned for longer periods to assist with efforts on the Strategic Agenda.

Regional meetings have also been useful in providing technical support for various subjects important to Indonesia. However, these meetings should be well-planned and provide sufficient advanced notice so that the most appropriate Indonesian staff members can attend.

One of the ways that WHO can assist Indonesia is by facilitating exchanges with other countries that are successfully dealing with problems similar to those in Indonesia as part of horizontal collaborations. For example, Indonesia's new efforts in preventing noncommunicable diseases could benefit from learning how other countries have successfully implemented policies and programmes in this area. This could be carried out through exchange visits between the countries or by consultations of staff members to Indonesia, providing advice about similar programmes. It should be noted that Indonesia has many similarities to countries in the Western Pacific Region of WHO, especially those in the Association of Southeast Asian Nations (ASEAN). Therefore, when appropriate, exchanges and meetings among countries in both WHO regions will be supported.

7. Working with health partners

As an agency of the United Nations, WHO has an obligation to support Member States and health organizations by providing, when requested, up-to-date information about health conditions and programmes in Indonesia. In addition, WHO supports efforts to exchange information with health partners in order to help avoid overlapping work and to discuss solutions to common problems facing partners. The H4Plus has been a successful example of this work in the area of maternal and neonatal health. However when useful, this group has been limited to UN agencies and efforts might be made to expand this to include bilateral agencies and key nongovernmental organizations in Indonesia when useful.

The coordination of health partners rests with the Ministry of Health. In the past, WHO has assisted the Ministry of Health in preparing meetings of health partners and is available to assist in similar efforts whenever requested.

8. Resource mobilization

As discussed in Section 4 above reviewing work in the previous CCS, about 80% of WHO's work was supported by voluntary contributions, mostly for specific projects. A large part of these project funds has been generated through global projects such as polio eradication. However, there is a trend for partners in Indonesia to work with the Country Office by funding specific activities supporting their projects. An example of this has been USAID's support of WHO's hospital accreditation work. These arrangements are possible when the WHO Country Office has the technical resources to assist the partner with work of common interest. While WHO does not have any field sites, partners often have implementation areas where WHO might assist with research or adapt international technical guidelines to field conditions in Indonesia. This requires close cooperation and forward planning by both WHO and the partner in order to ensure that the appropriate resources are available. Furthermore, this should enable the funding of necessary technical staff over a longer period of time.

Additional resources are needed to cover the work required to achieve significant progress in the Strategic Agenda. Thus, WHO should work closely with partners at all levels to mobilize the necessary resources for this work. It is also expected that the Region Office will assist with these efforts, especially by meeting with possible donors during visits to the country, further exploring common interests and preparing specific proposals and workplans. Finally, the Country Office should not accept donor resources that do not match the priorities in the Strategic Agenda, urging them to support activities within this agenda.

9. Workplans to implement the Strategic Agenda

The most important use of the Country Cooperation Strategy is the formulation and implementation of WHO workplans in its biennium planning cycle. Once the CCS has been finalized and approved, the current workplans of the 2014–2015 biennium will be reviewed to see how they can be modified to reflect the new Strategic Agenda. At the same time, preliminary budgets for 2016–2017 need to be reviewed to make modifications to reflect the new Strategic Priorities. Both these initiatives, as well as a review of the technical staff in the Country Office, need to be made without delay to ensure full implementation of the new Country Cooperation Strategy.

10. Evaluating the Country Cooperation Strategy (2014 – 2019)

In order to evaluate this new Country Cooperation Strategy, it is recommended that there be a mid-term review in early 2017. This will allow a review of work to make necessary modifications in the CCS and to develop the 2018–2019 workplans for the final period of implementation. The final CCS review should be conducted in mid-2019 to coincide with the development of the next Country Cooperation Strategy. During this period it is expected that the Government and the Ministry of Health will be developing their own plans for the next medium term plans for the period 2020–2024. At this time, WHO's new General Programme of Work should also be available to guide WHO's own priorities. This will ensure that the work of WHO is in-line with the changing priorities of the Indonesian Government and the Ministry of Health.

Blurb yet to come



**World Health
Organization**
Country Office Indonesia