

ANNEX B to the report *Flow of Donor Funds in Cambodia, Indonesia and Sri Lanka: Synthesis of Key Findings*

EXTERNAL RESOURCE FLOWS TO THE HEALTH SECTOR IN INDONESIA

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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
DOTS	The internationally recommended control strategy for Tuberculosis
CGI	Consultative Group on Indonesia
GAVI	The Global Alliance for Vaccines and Immunization
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GOI	Government of Indonesia
MDG	Millennium Development Goals
NHA	National Health Accounts
USAID	United States Agency for International Development
WB	The World Bank

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EXTERNAL RESOURCE FLOWS TO THE HEALTH SECTOR IN INDONESIA

This report represents a first attempt to document the flow of external funds to the health sector in Indonesia. Findings reported are based on the available information from multiple data sources. It is nevertheless preliminary, and should be followed by more detailed studies to refine estimates provided here.

COUNTRY CONTEXT

Indonesia is the fourth largest Muslim country in the world with a population of 212 million in 2002. It ranks fourth in population size after China, India and the United States. Its 6,000 inhabited islands comprise rich and very diverse cultures, and span a vast area in the South China Sea (see **Figure 1**). The inauguration of the first directly elected President, Dr. Susilo Bambang Yudhoyono in October 2004 attests to the success of peaceful political transition towards democracy.

Two events - the Asian economic crisis in 1997-98 and the so called “Big Bang” decentralization mandated by Presidential decree, which took effect January 1, 2001 – have profound implications for the health sector.

The Asian economic crisis was a major set back in the development of the country. It increased the already high share of population living in poverty and exposed the close links between economic development, poverty and health. It heightened the vulnerability of households that were just above the poverty line to falling into poverty as a result of poor health. External donors buffered the potential devastating impact of the crisis by increasing funding targeted to the poor. In the past few years, levels of poverty gradually reversed to their pre-crisis levels. Although the pace of economic recovery has been slower than in neighboring countries, Indonesia completed its IMF supported program in December 2003. The country “has made remarkable progress in achieving macroeconomic stability, in reducing the economy’s vulnerability, and restoring external visibility”¹.

Strikingly, health has remained a low priority in the macro-economic reconstruction of the country. Indonesia allocates a smaller share of its GDP to health, and lags behind neighboring countries with comparable economic development in all health outcomes. Many poor households, particularly in rural areas, still lack access to good quality health care (see **Table 1**). The decentralization set forth a bold and abrupt transition from a highly centralized health system to one of the most decentralized health systems in the world. It included two major components: a shift of authority to the local level, and a partial reallocation of government spending from the central level to over 300 districts.

¹ World Bank Brief for the Consultative Group on Indonesia. Indonesia: Beyond Macro-Economic Stability. The World Bank, Report No. 27374 –IND, December 2003.

The Government of Indonesia's (GOI) budget comprises two distinct components: a regular budget (covering salaries of all public servants) and a development budget. The share of the development budget that was transferred to each district was provided as a general block grant (Dana Alokasi Umum–DAU) covering several sectors (e.g. education, health, and other sectors) with little guidance on how these funds should be spent. The target is to allocate 10-15 percent of the development budget to the health sector, but very few districts have yet met this target. There are no mechanisms to enforce this recommendation. The health sector still remains partly centralized as the central government still controls still finances approximately 50 percent of development and 25 percent of routine expenditures in health²

The process of decentralization poses complex and difficult challenges, and is changing ways by which external donors, the Government of Indonesia and stakeholders interact at central, provincial and district levels. The next sections describe the flow of external financial resources within the country and recent trends; discuss how major donors are responding to key challenges, with particular attention to aid effectiveness.

DATA SOURCES

Data sources included policy, planning and project documents; reports from donor coordinating groups – the Consultative Group on Indonesia (CGI) and Partners in Health; financial information on commitments and disbursements provided by government budgets, donor agencies within the country; and financial reports that were available on the internet.

Discussions with key stakeholders (government, donors, and NGOs) contributed invaluable insight into key challenges in developing strategies that are responsive to the priorities of recipient countries, and ways to improve aid effectiveness. The list of people consulted is provided in Appendix II.

KEY FINDINGS

Disbursements from external funding sources in 2002

The year 2002 was the most recent year for which complete information on disbursements of funds provided by external financing sources was available³, when the study was conducted in May 2004. Disbursements are funds that have been spent in 2002. These convey what actually happened, whereas commitments represent the funds made available for projects, programs and technical assistance. Funds initially committed may be disbursed, reduced, cancelled or increased as activities proceed.

² Sparrow R. and Menno P. Governance in the health sector in Indonesia since decentralization. Free University of Amsterdam and the World Bank. September 2003.

³ Financing sources: institutions or entities that provide the funds used in the system by financing agents.

Total disbursements from external sources to the health sector in Indonesia in 2002 amounted to US\$ 188.2 million. Multilateral agencies (Development Banks and UN agencies) contributed approximately two thirds of total disbursements, and bilateral agencies the other third. The share of development assistance from the Bill & Melinda Gates Foundation directly, and from public-private partnerships was very small (2.5 percent). These estimates do not include contributions from international NGOs' own funds, for which data was not available (see **Figure 2**).

The three largest external financing sources were the Asian Development Bank (ADB) – US\$72.4 million; USAID – US\$ 35.6 million; and the World Bank – US\$ 20.6 million. USAID contributed just over half of all bilateral funds, and Korea, Japan, Australia, Canada, Spain and Germany the other half. WHO, UNICEF and UNFPA jointly contributed US\$ 25.8 million (see **Table 2**).

Donor funds are channeled through financing agents, which use the funds provided by financing sources and use those funds to pay for, or purchase the activities inside the health sector boundary (see **Figure 3**). The choice of financing agents⁴ differed among donors. Donors channeled their funds either directly to the Government of Indonesia “on-budget”, or outside of it “off-budget”. The largest share of external funds (US\$117.7 million) was channeled directly through the Government of Indonesia – that acted as the financing agent for (a) grants and loans from ADB and WB; and (b) bilateral funds provided by Korea, Japan, Germany and Spain. The balance (US\$76.6 million) was not channeled through the Government. Local offices of USAID, and the UN agencies handled their own financial transactions. Finally Australia and Canada channeled a share of their funds to UN agencies as extra-budgetary resources or to foreign contractors in charge of specific projects.

Providers⁵ include the public health sector (central government; provincial and district governments; and national control programs) and the private non-profit sector (mostly international and local NGOs). The public health sector was the main recipient of 80 percent of all funds of which an estimated US\$51 million went to the central government; US\$89 million to provincial and district governments and US\$10 million to National Control Programs. About US\$38 million went to foreign and local NGOs.

Information pertaining to the allocation of external funds to specific components was available for all multilateral agencies, major bilateral donors, and public-private partnership – which provided about 80 percent of total disbursements in 2002. We categorized the allocation of funds into four major components: (i) health systems and health services (51 percent); (ii) maternal and child health, including immunizations (26 percent); (iii) infectious diseases – HIV/AIDS, tuberculosis and malaria (14 percent); and

⁴ Financing agents: institutions or entities that channel the funds provided by funding sources and use the funds to pay for, or purchase, the activities inside the health accounts boundary. (Reference: Guide to producing national health accounts with special applications for low-income and middle-income countries. WHO 2003).

⁵ Entities that receive money in exchange for or in anticipation of producing the activities within inside the health accounts boundary

(iv) reproductive health, including safe motherhood (11 percent) (see **Table 3** and **Figure 4**).

The ADB and the WB funded provided almost all funds to strengthen health services and to support health sector decentralization. A much larger group of donors, mostly UN agencies, USAID, other bilateral agencies and the Global Alliance for Vaccines and Immunization (GAVI) provided technical assistance and/or financial support for maternal and child health, immunization, safe motherhood and reproductive health projects and programs. USAID provided two thirds of all funding to prevent and control major infectious diseases (HIV/AIDS, tuberculosis, and malaria). The other third came mostly from the WHO country office.

All regions and provinces in Indonesia received external funds. The most striking feature is the great heterogeneity that exists between regions as well as between provinces in the same region. Differences pertain to demographic and socio-economic indicators, as well as to health outcomes, no single one of which appears to be a major determinant of the allocation of external funds. For instance, the ADB and the WB provided funds to support the decentralization of health systems and to strengthen health services in most provinces of Java, Kalimantan, Sulawesi, Sumatra and in Bali but did not fund health systems and health services in the Eastern provinces of Indonesia. In contrast Australia focused most of its funding in the Eastern Provinces. USAID targeted most of its funding in JAVA and Sumatra which comprise 80 percent of the total population (see **Table 4**). Appendix A provides a detailed listing of loans and grants that were active in 2002 for major donors.

Recent Trends in Commitments and Disbursements

Since 2002, important changes have occurred in the contributions of different external financing sources. The most notable is the rapid increase in commitments and disbursements from GAVI and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

Three proposals were accepted for funding by the GFATM in June 2003, with a total funding request of US\$ 109.5 million for five years, of which US\$ 36.8 million was approved for the first 2 years to (i) strengthen the expansion of the internationally recommended control strategy for Tuberculosis (DOTS) in Indonesia (US\$ 21.6 million);(ii) intensify malaria control in four provinces of Eastern Indonesia (US\$ 8.3 million); and (iii) prevent and alleviate the impact of HIV (US\$ 6.9 million). US\$ 28.4 million had been disbursed by the end of January 2005 (see **Table 5**, **Figure 6** and **Figure 7**). Trends in disbursements for each of the three projects show that cumulative disbursements increased rapidly during the second year (see **Figure 8**). A fourth grant agreement for HIV/AIDS comprehensive care was signed in January 2005 for a total of US\$ 65 million over five years, of which US\$ 31.1 million have been approved for the first two years. Since brings the total funding approved for 2 years since June 2003 to US\$ 67.9 million and the total funding request to US\$ 175.4 million.

GAVI/Vaccine Fund committed US\$40.1 million for five years (2002-2007) to support immunization services (US\$16 million), injection safety (US\$10.7 million), Hepatitis B Uniject (US\$13.2 million), and US \$0.1 million for other support. US\$ 15 million had been disbursed by the end of 2004 (see **Table I.10**).

The large increase in external funding for HIV/AIDS, tuberculosis and malaria, and for immunizations has not been matched by similar increases for the other major components. Trends for commitments and disbursements of World Bank loans to the health sector were available since 1996. Three-year average commitments increased from US\$ 38.6 in 1998 to US\$ 87.8 in 2000, and subsequently decreased to US\$ 52.8 million in 2003. In contrast, disbursements have remained steady around US\$ 20 million per year between 1998 and 2002, increasing only in 2003 to US\$ 33.1 million. Detailed trends in disbursements were not available for the ADB.

DISCUSSION

Two broad policy questions lie at the core of discussions of external funding to the health sector:

1. How responsive is the allocation of funds to needs and priorities of the recipient country?
2. How effective is development assistance in reaching its objectives?

Responsiveness to country needs and priorities

The most immediate needs in Indonesia are to support and strengthen the decentralization of the health sector while at the same time improving maternal and child health, and reducing the burden of major infectious diseases, all of which are important health MDG targets. The Millennium Development Goals (MDGs) provide a common platform to define priorities which donors, the Government of Indonesia, and other stakeholders jointly endorse. There is also a growing recognition that strengthening the capacity and capability of the health sector is critical to successfully scale up proven cost-effective interventions, and reach the poorest populations. While this is true in a very large number of countries, which have weak public health systems and lack human resources, the need to strengthen the public health sector takes on even more urgency in Indonesia to ensure the success of decentralization.

The sectoral long term plan for health includes six broad program areas, each of which is further broken down into specific programs, which include activities, performance indicators and agencies involved (Healthy Indonesia 2010):

- Safe and healthy environment, healthy lifestyles behavior, community empowerment;
- Health program effort interventions (which includes communicable diseases);

- Community nutrition program;
- Human resource development, health sector;
- Food, drug, and dangerous stuff administration; and
- Development policy and management of development.

One difficulty arises from the fact that health sector plans are not directly linked to budgets.

Health sector and human resource development

Decentralization raises complex questions of governance, financing, political will, and health sector capability and capacity at the central, provincial and district levels – all of which are impacting strategies and priorities of external donors as they contribute a large share (an estimated 25-30 percent) of the development budget.

The health system in Indonesia is facing very difficult challenges in coping with the abrupt decentralization of the health system that took effect January 1, 2001. Few rules guide the allocation of block grants between sectors and there is little guidance regarding funding of different programs within the health sector. Although the recommendation is to allocate 10-15 percent of block grants to the health sector, this target has rarely been met and there is no mechanism to enforce it. The capacity of government bureaucracies is generally weak, and so is service delivery. Local financing for the health sector depends at least in part on the political will of government officials.

The ADB⁶ and the WB⁷ provided most of the financing to strengthen the health sector, in response to a request from the GOI, with a total disbursement of US\$ 78 million in 2002. It is important to note that these funds are in fact borrowed money that has to be fully repaid. Most loans to Indonesia are non-concessional loans.

The main objectives of these loans were to avoid the breakdown of the delivery of health services that may be caused by the rapid implementation of decentralization, bring about effective health sector decentralization and help the central health ministry carry out its new role in a decentralized system (See **Appendix Tables I6 a,b;I7 a,b**). ADB and WB loans were provided to all districts in 18 of the provinces, with limited geographic overlap in four provinces (see **Table 4**).

In contrast UN agencies, bilateral donors, and the non-for profit sector provide grants to support the provision of health services, human capacity building, and technical assistance. They generally have a more limited geographic focus to several districts in a limited number of provinces and tend to focus on specific health problems rather than on the overall functioning of the health system (see **Appendix Tables I1-A5 and I8-A10**).

Major Causes of Disease Burden

⁶ Health and nutrition sector development program; second and second decentralized health services project

⁷ Fifth health project; first and second provincial health projects; health workforce and health services projects

Indonesia is lagging behind other countries in the region in major basic indicators of population health. It is also the country with the third highest number of cases of tuberculosis. Indonesia is committed to reaching MDG targets in health and other sectors and completed its first Progress Report in February 2004 (Indonesia, Progress Report on the Millennium Development Goals). Health MDGs⁸ provide a common platform for joint action of the GOI and external donors. Indeed approximately half of all external disbursements in 2002 were allocated to HIV/AIDS, tuberculosis, malaria, maternal and child health, immunization and reproductive health. The relative share of funds allocated to each of these components has changed since 2002 with additional support from the GFATM for the HIV/AIDS, tuberculosis and malaria starting in 2003.

A key question than is the extent to which external funds address specific needs identified by the country in each broad area, and fill funding gaps to meet specific MDG targets. A full blown analysis of funding provided by different financing sources and projections of projections of costs to reach specific MDG targets is not available, with a few exceptions. The National Tuberculosis Control Program Strategy conducted a critical analysis of the shortcomings of the Program, which had to be addressed; developed a detailed accounting of the actual costs; estimated funding gaps and based on this, submitted a successful request for the additional funds needed to the GFATM.

The broader question pertaining to the impact of the very large investments in major communicable diseases supported by the GFATM on other priority areas, particularly maternal and child health cannot be easily answered as long as health sector planning and budgeting are not linked.

Aid Effectiveness

Broad agreement on the most important priorities does not automatically create a strong synergy between donors and the government, as well as among different donors. In fact donors have their own priorities and strategies; tend to operate quite independently from each other, and work more or less closely with the public health sector.

Donor coordination and harmonization

The Consultative Group on Indonesia (CGI) is the main mechanism for coordination among all donors. It was established at the request of the GOI, provides the main forum to review and develop strategies to strengthen the macroeconomic situation in the country. The GOI and the World Bank jointly chair the CGI.

Partners for Health is the major mechanism for coordination between donors in the health sector. WHO hosts regular meetings of the group, which is open to all interested donors to the health sector. It only recently became an active working group within the CGI.

⁸ Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate; Reduce by three-quarters, between 1990 and 2015, the maternal mortality ration; Have halted by 2015 and begun to reverse the spread of HIV/AIDS; Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

This reflects a characteristic of development aid to Indonesia, which is the low importance that has been given to the health sector in the broader development of the country. The prevailing view still is that better health will follow economic development rather than a driving force of development. This is further reinforced by the low percentage of total public health sector budgets allocated for health.

Discussions with several donors emphasized that Partners in Health needed to evolve from being primarily a forum for exchange of information ‘show and tell’, rather than an effective forum for the formulation of joint strategies and for much more pro-active discussions of common problems. As a result little effort has yet been made to harmonize donor practices.

THE ROLE OF THE COMMISSION ON MACRO-ECONOMICS AND HEALTH

The Indonesian context is not very receptive to the major findings and recommendations of the CMH as the prevailing paradigm considers that economic development and political stability are the major driving forces, and do not recognize the importance of increasing investments in the health sector. The implementation of the main recommendations of the CMH report to increase external and national resources allocated to the health sector remains an extremely difficult challenge given that health is not considered to be a driving force of further economic development by national and external funding sources alike. As a result funding provided by the GOI and external donors fall far short of what would be needed to rapidly improve health outcomes, particularly among the poorest populations. In this context, even modest increases in external and public sector expenditures for health resulting from the CMH country efforts, would represent a major step in the right direction.

The Partners in Health Group therefore are key in promoting an alternative paradigm within the CGI. This will take time and will require continued strong commitment and leadership of a few members of Partners in Health. The WHO team has already invested considerable energy to move the process forward. They will need continued support from the CMH Secretariat to succeed in bringing about real change, but this can be done.

TABLES AND FIGURES

TABLE 1: INDONESIA –Selected Indicators 2001-2002

DATA SOURCES	SELECTED INDICATORS	
World Health Report, WHO 2004	Population 2002 (millions)	217
	GDP per capita \$ 2002	710
	Population below the National Poverty Line	17.1
	Total expenditure on health as % of GDP	2.4
	Total expenditure on health p. capita (US\$)	16
	General government expenditures on health (as % of total government expenditures)	3
	Government expenditure on health p.capita (US\$)	4
	General government expenditures on health (as % of total expenditures on health)	25.1
	Private expenditures on health (as % of total expenditures on health)	74.9
	Life expectancy at birth (both sexes)	66.4
Indonesia MDG Progress Report, 2004	Infant mortality rate (per thousand live birth)	35.0
	Mortality rate of children <5 yr old	46.0
	Maternal Mortality (per 100,000)	307
	Malaria prevalence p.100,000	850
	HIV/AIDS prevalence (pregnant women)	2.7
Global Tuberculosis Control, WHO 2004	TB prevalence (per 100,000)	272
	TB mortality (per 100,000)	59

TABLE 2: External Funding Sources: Total Disbursements 2002

Funding sources		US\$ (millions)
I. Bilateral agencies		64.9
<i>of which:</i>	USAID	35.6
	Korea	8.7
	JICA	6.6
	AusAID	5.4
	CIDA	5.2
	Spain	2.0
	Germany	1.3
II. Multilateral agencies		118.8
<i>of which:</i>	World Bank	20.6
	Asian Development Bank	72.4
Development Banks sub-total		93.0
	WHO total	12.5
	UNICEF total	7.0
	UNFPA	6.3
UN agencies sub-total		25.8
III. Public -private partnerships		3.7
	GAVI	3.7
IV. Private non-for-profit		0.9
	Gates Foundation	0.9
Total		188.2

TABLE 3: Implementing Agency by Funding Source and Activity

Funding Source	Activity	Implementing Agencies/Counterpart Agency
USAID		
	Tuberculosis	National Tuberculosis Program
		Tuberculosis Coalition for Technical Assistance
AusAID		
	Healthy Mothers Healthy Babies	Directorate General for Community Health Development, Ministry of Health
	Implementing Maternal Health in Eastern Indonesia	UNICEF
	UNICEF Safe Motherhood Program	UNICEF, through Provincial and District Health Agencies, local governments and community organizations
JICA		
	MCH Handbook	Ministry of Health
	Technical Cooperation South Sulawesi	Department of Health
CIDA		
	Reproductive Health Family Planning Commodity Security Support Project	UNFPA
	Nursing Women's Health and Community Outreach	U. of Indonesia in partnership with Memorial U. of Newfoundland
	Indonesia Fight TB Project	World Vision
World Bank		
	Intensified Iodine Deficiency Control Project	Directorate General of Community Health, Ministry of Health
	Safe Motherhood Project: A Partnership and Family Approach	National Coordinating Board for Family Planning (BKKBN) and Ministry of Health
	Fifth Health Project	Secretary General, Ministry of Health
	Provincial Health Project	Secretary General, Ministry of Health
	Second Provincial Health Project	Secretary General, Ministry of Health
	Health Workforce and Services Project	Secretary General, Ministry of Health, Director General of Higher Education, Ministry of National Education
ADB		
	Family health and Nutrition Project	National Coordinating Board for Family Planning (BKKBN) and Ministry of Health
	Health and Nutrition Sector Development Program	Ministry of Health
	Second Decentralized Health Services Project	Bureau of Planning, Ministry of Health
GFATM		
	Prevention and Alleviation of HIV Impact	Directorate of Directly Transmitted Disease Control, Ministry of Health
	Indonesia HIV/AIDS Comprehensive Care	
	Strengthening DOTS Expansion in Indonesia	
	Intensified Malaria Control in Four Provinces of Eastern Indonesia	Directorate of Vector Borne Disease Control, Ministry of Health
GAVI		
	Support for Immunization	Central level: Center for Disease Control and Environmental Health

TABLE 4: Disbursements 2002: Allocation of External Funds to Specific Components, Selected Agencies (US\$, millions)

Selected Components	TOTAL	Bilateral ODA			UN Agencies			Development Banks		Private non profit and PPPs	
		USAID	JICA	CIDA	WHO	UNICEF	UNFPA	WB	ADB	BMGF	GAVI
HIV/AIDS	7.6	7.3			0.3						
Tuberculosis	7.9	2.0		2.8	2.1	1.0					
Malaria	1.1	0.6			0.5						
Communicable Disease Surveillance/Prevention Eradication and Control	0.3	0.0			0.2						
sub-total Communicable Diseases	16.9	9.9		2.8	3.2	1.0					
Immunization	9.8				3.5	2.5					3.7
Maternal and Child Health	29.7	15.4	3.3	0.3	0.4	3.0		2.5	4.8		
sub-total Immunization and Child Health	39.5										
Safe Motherhood	3.6				0.4			3.2			
Reproductive Health	17.6	10.3		2.1	0.1		4.2			0.9	
sub-total MCH, Safe Motherhood and Reproductive Health	21.2	25.7	3.3	2.4	4.4	6.4	6.3	5.7	4.8	0.9	3.7
Strengthening health services	7.7		3.3					4.4			
Support to health sector decentralization	70.6							3.0	67.6		
sub-total Health system and Health services	78.3		3.3					7.4	67.6		

TABLE 5: Geographic Allocation of External Funds to Selected Components, 2002

Region	Province	Population (million)	Percent below			USAID	AusAID	JICA	CIDA	UNICEF	World Bank	ADB
			Poverty line	IMR	U5MR							
Java		124.3										
	Banten	8.6	6.2	38	46		MCH			MCH	Health Services	
	Central Java	31.8	23.4	36	44	TB, MCH				MCH	Health Services	Health Services
	D.I. Yogyakarta	3.2	20.1	20	23	TB					Health Services	
	DKI Jakarta	8.4	3.4	35	41	RH	HIV/AIDS					
	East Java	35.2	21.9	43	52	TB				MCH	MCH	
	West Java	31.2	13.4	44	50	TB	MCH, HIV/AIDS		RH	MCH	Health Services	
Kalimantan		11.8										
	Central Kalimantan	2.0	11.9	40	47						Health Services	Health Services
	East Kalimantan	2.6	12.2	42	50						Health Services	
	South Kalimantan	3.1	8.5	45	57							Services
	West Kalimantan	4.2	15.5	47	63				RH		Health Services	Health Services
Sulawesi		15.4										
	Central Sulawesi	2.3	24.9	52	71							MCH
	North Sulawesi	2.1	11.2	25	33			MCH				Health Services
	South Sulawesi	8.3	15.9	47	72			Health Services		MCH		Health Services
	South-East Sulawesi	1.9	24.2	67	92		MCH, HIV/AIDS					Health Services
Sumatra		44.8										
	Aceh	4.0	29.8									Health Services
	Bengkulu	1.7	22.7	53	68	TB						Services
	Jambi	2.5	13.2	41	51	TB					Health Services	MCH, Health
	Lampung	6.9	24.1	55	64	TB, RH					Health Services	
	North Sumatra	11.9	15.8	42	57	RH					Health Services	MCH
	Riau	5.4	13.6	43	60							Health Services
	South Sumatra	7.2	22.3	30	49	RH						Health Services
	West Sumatra	4.3	11.6	48	59				RH		Health Services	
								MCH				
Other Islands		15.6										
	Bali	3.2	6.9	14	19	TB	HIV/AIDS					Health Services
	East Nusa Tenggara	3.9	30.7	59	73		MCH, HIV/AIDS		TB, RH	MCH		
	Maluku	1.2	34.8				MCH			MCH		
	Papua (Irian Jaya)	2.4	41.8			HIV/AIDS	MCH, HIV/AIDS			MCH		
	West Nusa Tenggara	4.2	27.8	74	103		MCH			MCH		

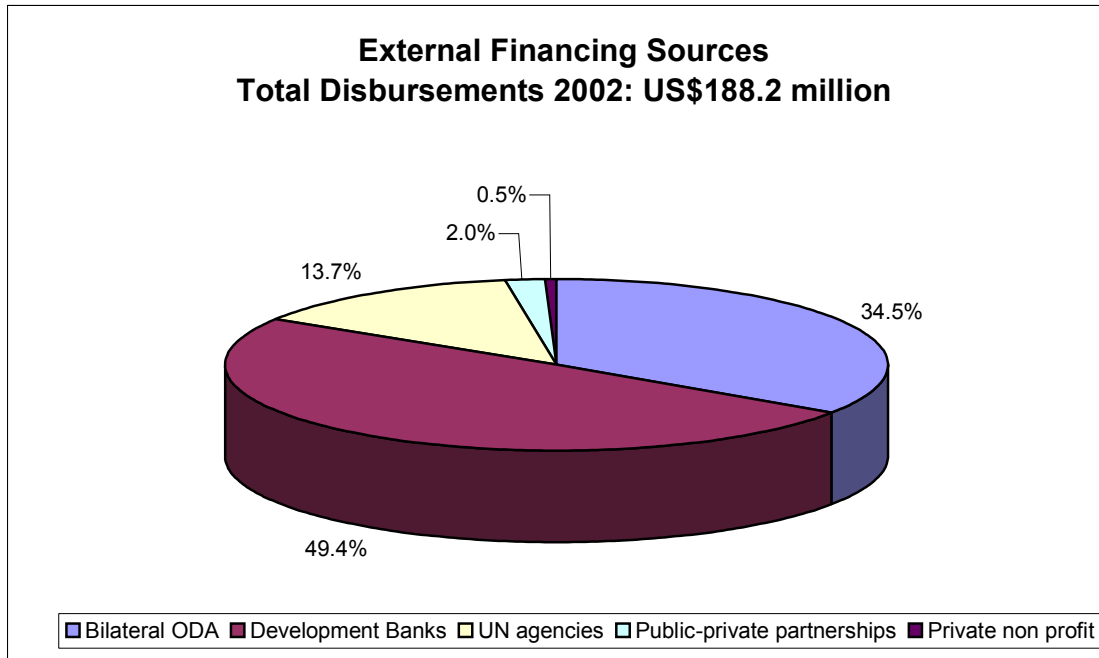
TABLE 6: Global Fund to fight AIDS, Tuberculosis, and Malaria: Funding Request and Approved Funding

GAFTM funds				
	Total	Prevention and Alleviation of HIV Impact	Strengthening DOTS Expansion in Indonesia	Intensified Malaria Control in Four Provinces of Eastern Indonesia
Total funding request (5-yr)	\$109,520	\$15,161	\$70,654	\$23,705
2-yr approved funding (000s)	\$36,792	\$6,925	\$21,612	\$8,255
Allocation			1. Provide comprehensive support, including uninterrupted supply of drugs to implement DOTS in resource-poor settings; 2. Achieve treatment success rate of 85% among new smear + cases beginning in 2003; 3. Expand and improve current activities to achieve WHO global targets for TB control by 2005	1. Reduce malaria morbidity/mortality by expanding case detection with help of rapid diagnostic tests, artemisin combination therapy, distribution of insecticide-treated nets, and indoor residual spraying
Links with existing activities			Aims at synergising, complementing and supplementing existing efforts towards TB control	
Principal recipient		Directorate of Directly Transmitted Disease Control of the MOH	Directorate of Directly Transmitted Disease Control of the MOH	Directorate of Vector-Borne Disease Control of the MOH
Implementing partners			A. Government health institutions at central/provincial/district and health centers - comprehensively for all components; B. Professional organizations/NGOs/Private Practitioners - varying degree of involvement depending upon their capacity and willingness	
Local Fund Agent		Price Waterhouse		
Financial Management		CCM will establish a project management unit that will prepare and submit 3 monthly budgets and financial reports		

FIGURE 1: Map of Indonesia



FIGURE 2: Total Disbursements from External Financing Sources, 2002



**FIGURE 3: INDONESIA – EXTERNAL ASSISTANCE TO THE HEALTH SECTOR
TOTAL DISBURSEMENTS 2002: US\$ 188.2 MILLION**

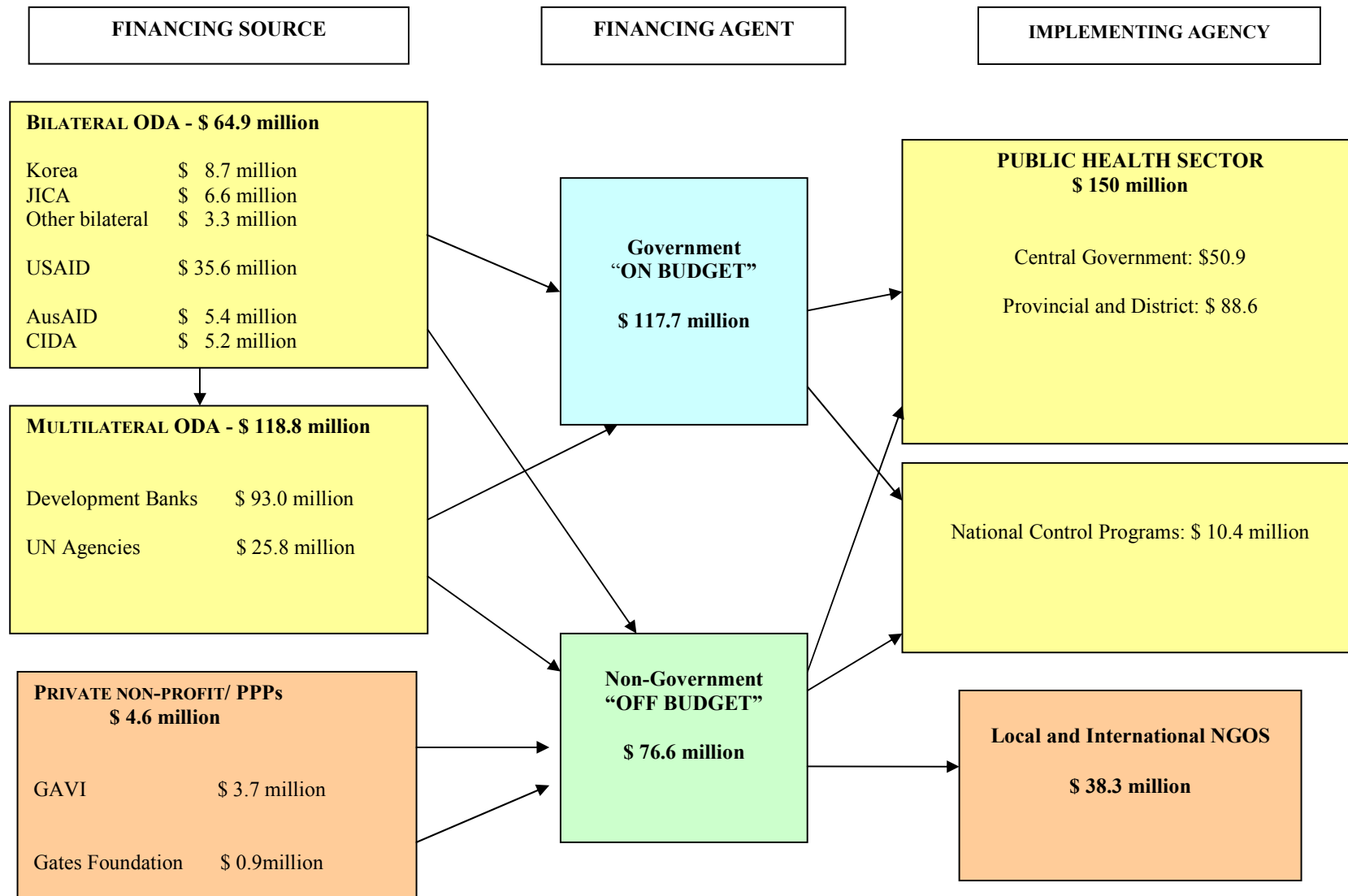


FIGURE 4: Allocation of External Funds by Major Components

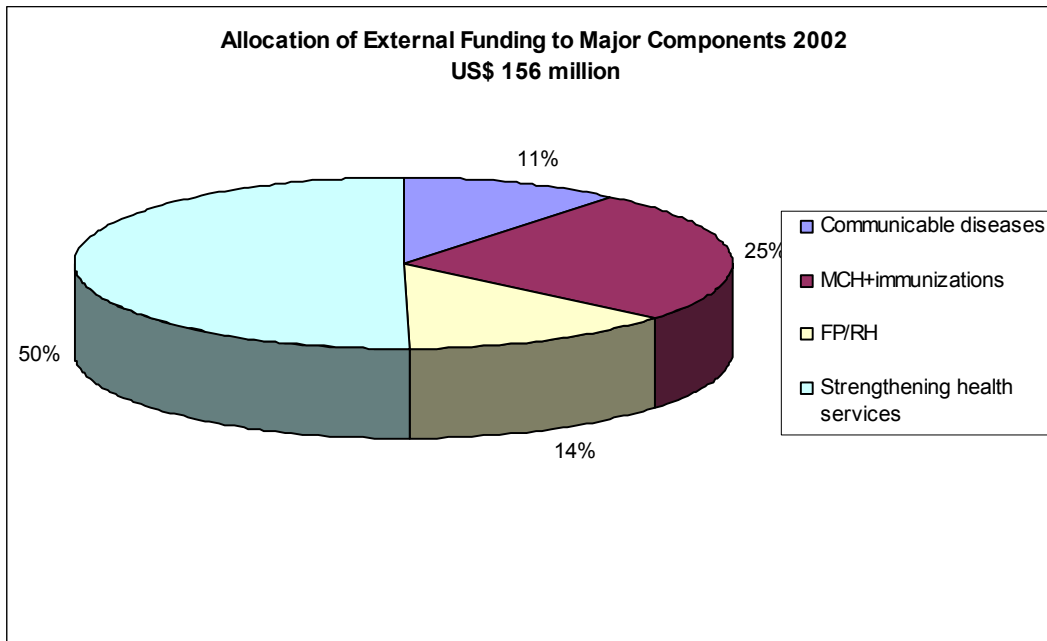


FIGURE 5: Disbursements for Selected Components, 2002

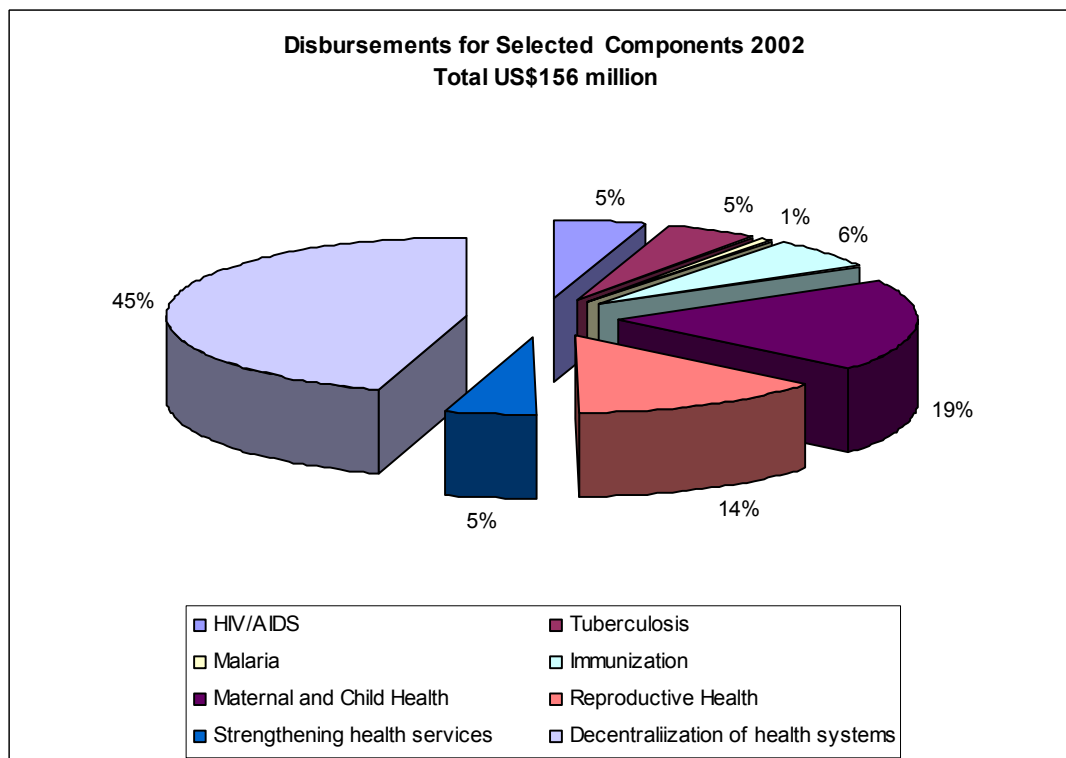


FIGURE 6: Allocation of GFATM Funds by Component

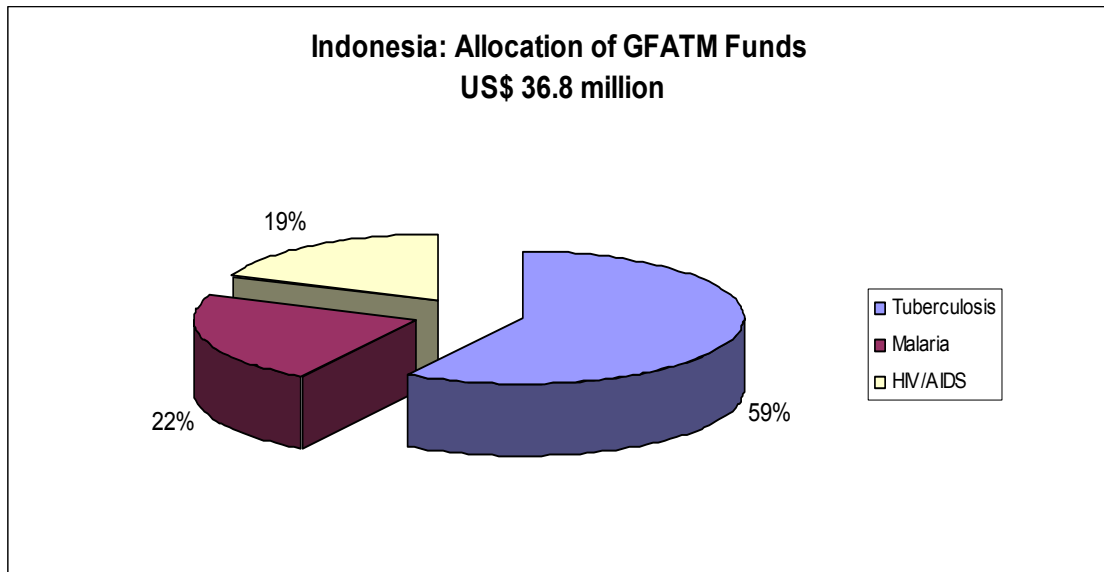


FIGURE 7: GFATM Cumulative Commitments and Disbursements, 2003-2004

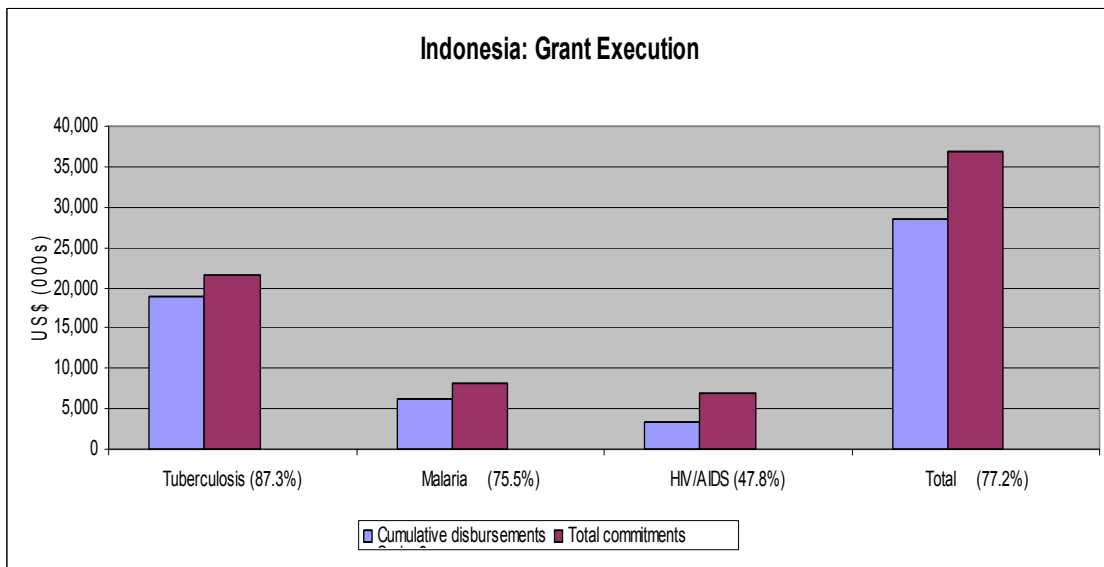


FIGURE 8

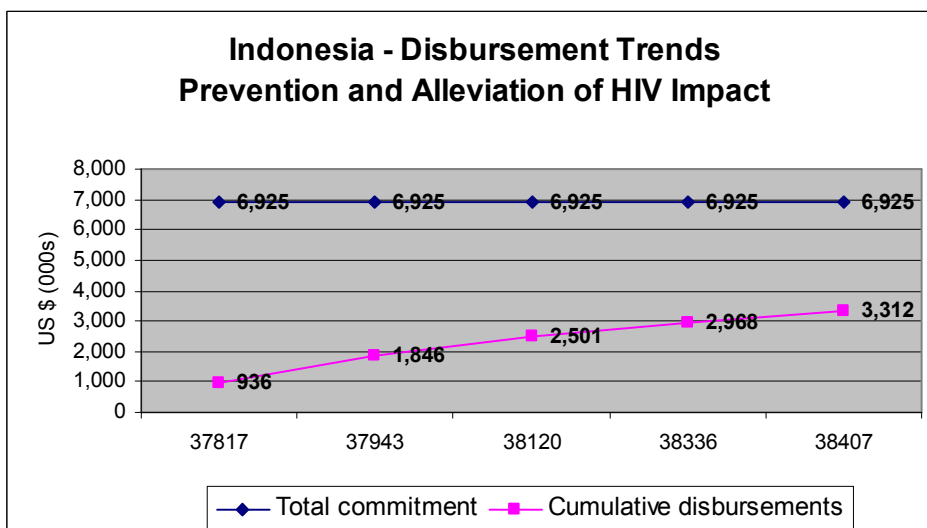
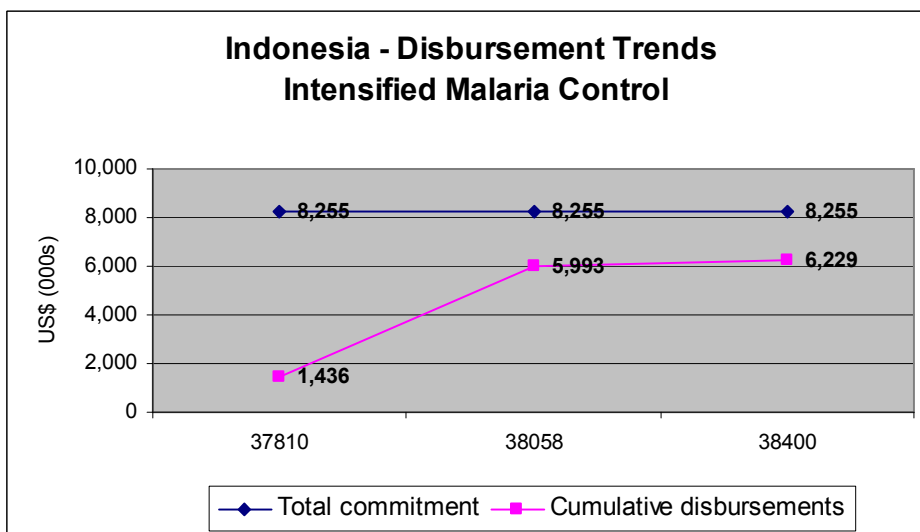
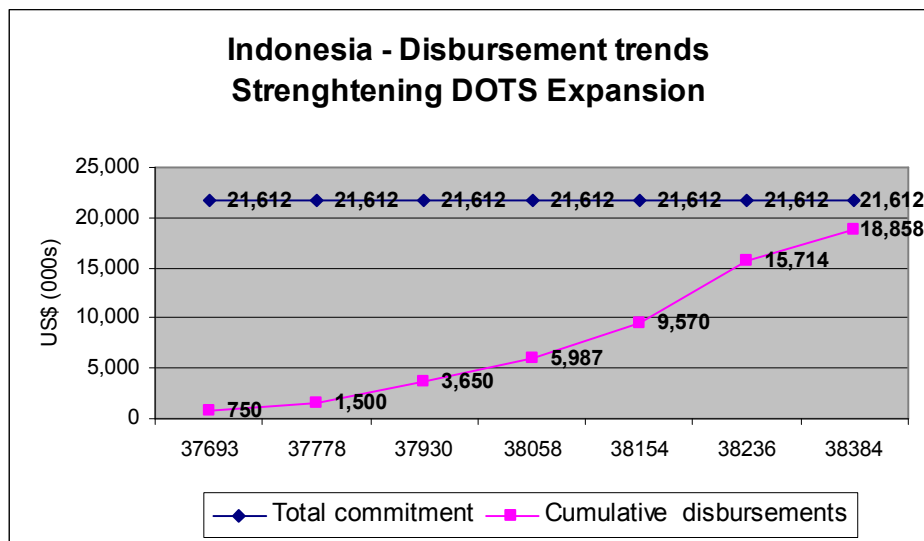
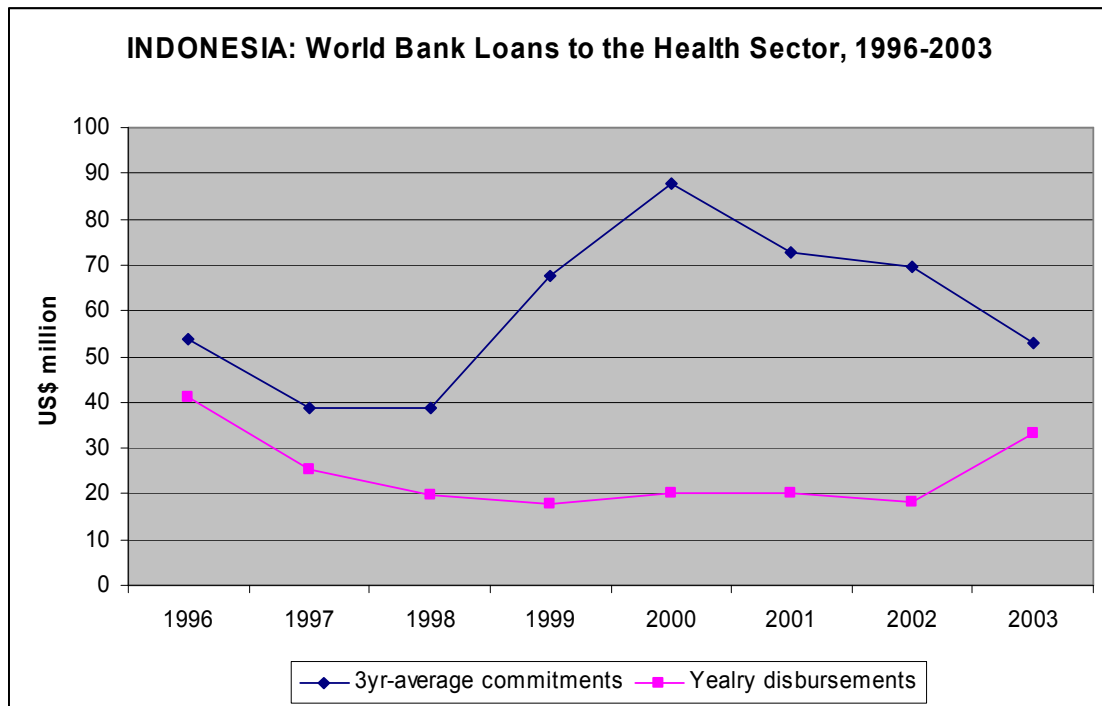


FIGURE 9



APPENDIX I

DETAILED ALLOCATION OF EXTERNAL FUNDS BY SOURCE

Table I.1: USAID - Detailed Activities 2002

	US\$ (millions)	Activity	Objectives and Scope	Target Population	Geographic area
	10.0	Family planning Reproductive Health	Support for improving the quality and choice of reproductive health services, maintaining contraceptive security and increasing focus on the reproductive health needs of Indonesia's youth.	Women and Youth	Jakarta and 6 provinces: 3 on Java; North Sumatra, South Sumatra and Lampung
	0.7	Vulnerable children		Street Children	4 major urban areas
	14.7	Child Survival and Maternal Health	Support for newborn and child health, micronutrient supplementation, and maternal health	Women and children	West Java, selected districts in East and Central Java
	7.3	HIV/AIDS	USAID technical assistance and training will support the GOI and Indonesian civil society national and local efforts to curb the spread of HIV/AIDS including increasing condom use, bolstering surveillance systems, and targeting results-oriented behavior change interventions within vulnerable populations. CSH infectious diseases funds will support tuberculosis control activities and the newly launched malaria control activity that will rollout vector control activities in Java .	Commercial sex workers; drug users	Urban centers throughout Indonesia; special focus on Papua
	2.0	Tuberculosis (2)	Establishing all elements of TB diagnostic and treatment systems (a) provision of laboratory equipment, computers and vehicle; supervisory visits to provincial and district health centers; implementing workshops and laboratory control; (b) enhancing the capacity of the national program through training and retraining of general and laboratory staff at district and health center levels; (c) conducting operations research		a) Central and East Java; b) Babel, Banten, Bengkulu, Jambi., Lampung, West Java, West Sumatra, Yogyakarta;c) Central Java, East Java, Yogyakarta
	0.3	Polio	Polio Eradication Initiative		Nationwide
	0.6	Malaria			
Total	35.6				

Table I.2: AusAID - Detailed Ongoing Activities 2002

Start/ End Dates	Total Commitment (US\$ millions)	Grant	Objectives and Scope	Target Population	Geographic area
12/97 - 1/05	14.2	Healthy Mothers Healthy babies	Support and strengthen the delivery of PHC services for women and children; improve the quality and coverage of ante-natal and post-natal care of women; improve preventive and curative services for children; increase the institutional capacity to deliver services. This is to be done, whenever possible, by supporting and strengthening existing activities and by close integration with Indonesian Department of Health programs, including those supported by other donors.	Newborn, mothers and children	South East Sulawesi (2 districts:Kendari and Buton)
6/98 - 4/04	10.1	UNICEF Safe Motherhood Program	AusAID funds UNICEF Safe Motherhood Program in 4 provinces with unacceptable high level of maternal mortality to strengthen the capacity of communities and government services at district level and below to reduce the level of maternal, infant, and under-five mortality	Newborn, mothers and children	Banten, Maluku, Papua, West Java,
9/02 - 9/07	18.5	Indonesia HIV/AIDS Prevention and Care project, phase 2	Consolidating and expanding previous support to the GOI at all levels for (i) policy and strategy formulation,(ii) innovative prevention and care initiatives, and (iii) fostering government and NGO partnerships.	Drug users, population at risk, PLWHA	Bali, DKI Jakarta, East Nusa Tenggara, Papua, West Java, South Sulawesi
7/02 -10/04	15.1	Women's Health and Family Welfare project, phase 2	Contribute to improved health of women and children by enabling GOI agencies and the local community to work together in partnership to identify and respond to problems of maternal and neonatal health and underlying gender issues. Specific objectives: (i) Improve the quality and accessibility of health care for women and their newborn infants; (ii) Promotion of Family Planning and Safe Motherhood.	Women of childbearing age	NTT: Sikka, Ende, Ngada, East Flores, Mangarri & Lembatta; NTB: East Lombok, Central Lombok, Bima and Dompu
2/03	6.2	Bali Health Assistance Package	(i) Assistance to Shanglah Hospita; (ii) Australia Bali Memorial Eye Center; (iii) Memorial Medical and Health Scholarship		Bali
4/03 - 10/04	1.2	ADB Decentralized Health Services project	Australian assistance funds two domestic and two international advisors who support district government health planners improve the quality and access of local services	Poor and vulnerable groups	Aceh, Bengkulu, Bali, Riau, North, Central and Southeast Sulawesi
1/04 - 6/06	5.0	Improving Maternal Health in Eastern Indonesia	Improve health services systems and behaviors that influence pregnancy and birth outcomes in 2 provinces. Specific objectives: (i) Ensure that all project districts are better able to plan, solve problems and coordinate maternal and neonatal health activities using national norms and standards; (ii). Strengthen institutions and systems in all districts to support the provision and management of comprehensive quality Emergency Obstetric Care services;(iii) Develop models for reducing pregnancy related risks and improving pregnancy outcomes; (iv) Increase the knowledge and participation of communities in improving pregnancy outcomes; (v) Ensure that sustainable structures and institutions are established and functional for project coordination, implementation and management.	Women of childbearing age	East Nusa Tenggara (East and West Sumba, Alor districts and Kupang city), and Papua (Jayapura, Jijijaya, Biak Numfor, Manokwari and Sorong districts)

Table I.3: CIDA - Detailed Ongoing Activities 2002

Start - End Dates	Total Commitment (US\$ millions)	Grant	Objectives and Scope	Target Population	Geographic area
9/98 - 12/04	0.5	Nursing Women's Health and Community Outreach	The overall rationale for the project is to strengthen the capacity of the Faculty of Nursing, University of Indonesia, to develop a comprehensive model of women's and community health services for rural Indonesia. Strategies involve education of all levels of nursing personnel - from post-graduate nursing to community health workers	Nursing personnel	Nationwide
5/99-3/05	2.5	Indonesia Fight TB Project	Support and strengthen the National Tuberculosis Control Program in reducing TB transmission by working in close partnership with the provincial and district local governments and the MOH. The project uses food inducements to help TB patients and their families with their nutrition requirements and also supports TB partners who are providing TB patients with psychological support to comply with the treatment program.	TB patients	Nusa Tenggara Timur (5 districts)
3/02-12/05	3.1	Reproductive Health Family Planning Commodity Security Support Project	The project supports the government's National Program covering all provinces in Indonesia with a particular focus on the 6th UNFPA country program provinces. UNFPA works with BKKBN to cover family planning needs for the poor. The project will also work with the Indonesian Planned Parenthood Association (PKBI) to ensure that unmarried men and women have access to family planning information and services. The project has 2 components: (i) family planning commodities; (ii) strengthening commodity security concerns specifically on targeting services to the poor according to BKKBN criteria for poverty.	Poor	Eastern part of West Java, East Nusa Tenggara, South Sumatra, West Kalimantan
3/02-3/05	0.1	Strengthening the National Nursing Association towards Health	The CAN-INN partnership aims to enhance INNA's governance and leadership capacity to advance the profession in Indonesia towards improving health outcomes	Nursing personnel	Nationwide
3/02-3/05	1.8	Global DOTS Expansion Program - Indonesia	Assist the GOI to implement the TB control 5-yr strategy in 4 provinces	TB patients	Banten, Bangka Belitung, Bengkulu, West Sumatra

Table I.4: JICA - Detailed Ongoing Activities 2002

Start - End Dates	Total Commitment (US\$ millions)	Grant	Objectives and Scope	Target Population	Geographic area
4/97 - 3/02	5.7	Technical Cooperation for Improving District Health Services in South Sulawesi	Improvement of skills of health professionals, ranging from senior level managers to nurses and midwives, using the problem solving oriented action research (PROAR) in the health center; and introducing a quality assurance system in central, district and Puskesmas laboratories.	Health care providers	South Sulawesi
10/98 - 9/03	5.5	Technical Cooperation for Ensuring the Quality of MCH through MCH Handbook	Production and use of MCH handbook to improve the quality of MCH services in both the public and private sectors	Health care providers, mothers and children	North Sulawesi and West Sumatra, with possible expansion to Bali, Bengkulu, East Java, Jogjakarta, South Sulawesi, West Nusa Tenggara,

Table I.5.a: WORLD BANK - Detailed Ongoing Activities 2002

Approval - Closing Dates	Original Loan Amount (US\$ millions)	Loan	Objectives and Scope	Target Population	Geographic area
12/96 - 12/03	28.5	4125-IND: Intensified Iodine Deficiency	Lower the prevalence of iodine deficiency	All	All provinces
7/97 - 12/04	42.5	4207-IND: Safe Motherhood Project: A Partnership and Family Approach	Includes central and provincial level components. Assist the GOI to improve maternal health status, reduce mortality and morbidity, through a partnership and family approach: (i) improve quality and utilization of maternal health services; (ii) strengthen sustainability of maternal health services at the village level;(iii) improving quality of family planning services; (iv) preparing adolescents to live healthy productive lives.	Women of reproductive age	Central and East Java
7/98 - 12/04	44.7	4374-IND: Fifth Health Project	Achieve greater efficiency of utilization and equity of distribution of health personnel; increase the skills of health professionals; and improve the quality of health professional practices	Health personnel and health professionals	Central Java, Central Kalimantan, Southern Sulawesi
6/00 - 6/06	38.3	Credit 3381-IND: First Provincial Health Project	Bring about effective health sector decentralization; help the central health ministry carry out its new role in a decentralized system. The project will proceed in two phases and consist of two main components. <u>The first component</u> sets the stage for decentralization and health reform, while helping to sustain the health social safety net introduced during the economic crisis. Task forces will address institutional and health sector issues, and assist in building district implementation capacity, including upgrading health information systems. Grants will be made available to districts to finance implementation of the recommendations made by the task forces and to reform and improve district level health services. <u>The second component</u> helps the central health ministry become an effective analytical, advisory, and advocacy agency; and provides grants to provinces and districts	Health personnel and health professionals	Lampung, D.I. Yogyakarta

Table I.5.b: WORLD BANK - Detailed Ongoing Activities 2002

Approval - Closing Dates	Original Loan Amount (US\$ millions)	Loan	Objectives and Scope	Target Population	Geographic area
6/01 - 6/07	103.2 Loan: 63.2/ Credit: 40	4269-IND/Credit 3537-IND: Second Provincial Health Project	1. Bring about effective health sector decentralization in 3 provinces; initiate key sector reforms and put health financing on a firm footing, while protecting essential health services for the poor and the public at large during a period of government restructuring; 2. Help the MOH carry out its roles in a decentralized system.	General population, with special attention of the poor	Banten, North Sumatra, West Java
6/03 - 12/08	105.6 Loan; 31.1/Credit 74.5	4702-IND/Credit 3784 -IND: Health Workforce and Services Project	Support health sector decentralization in four provinces for sustainable financing and client-centered delivery of health services. The main objectives are to (i) improve financing and delivery of essential health services in the participating provinces to enhance access to care, quality of care and health outcomes at the district level; and (iii) strengthen health workforce policy, management and development in a decentralized context in order to improve allocative efficiency and equity in the distribution and use of health resources in the districts. A corollary development objective is to empower the MOH, the Ministry of National Education and the Indonesian Medical Association, the three stakeholders in the sector through : (a) assistance to redefine their roles and responsibilities vis-a-vis health workforce policy, planning and management; and (b) building their institutional capacity for effective stewardship in fulfilling the functions of policy making, legislation, regulation, quality assurance and control, and technical assistance to provinces and districts.	Health personnel and health professionals	Jambi, East Kalimantan, West Kalimantan, West Sumatra

Table I.6.a: ASIAN DEVELOPMENT BANK - Detailed Ongoing Activities 2002

Approval - Closing Dates	Original Loan Amount (US\$ millions)	Loan	Objectives and Scope	Target Population	Geographic area
9/96 - 12/03	39.6	Family Health and Nutrition Project	The goal of the project is to improve the health status of the population and to ensure that this improved health status is maintained. The specific objectives are to (i) improve health indicators; (ii) ameliorate nutritional status; (iii) reduce total fertility rate. The project will increase the capacity of the families and their village community to make informed decisions and take action to directly improve the health and nutrition of their members, and improve the capacity of the health services providers to provide quality services, with the support and participation of local leaders and local governments.	Health personnel and health professionals; poor and vulnerable groups	Bengkulu, Jambi, North Sumatra, Central and South Kalimantan
3/99 - 12/02	200.0	INO 32516- (OCR): Health and Nutrition Sector Development Program	The primary goal for the program is to mitigate the effects of the economic crisis on the poor. The specific objectives are to (i) protect access by vulnerable groups to essential health and nutrition services; (ii) maintain the quality of services provided to the poor; (iii) initiate sustainable policy reforms related to the provision of health and nutrition services. It comprises two parts: a policy reform program and an investment project complemented by TA. The program will support nationwide policy reforms designed to maintain access of the poor to basic health services and strengthen decentralized management of health services delivery. The project will provide funds for maintaining access and quality of services to the poor	Health personnel and health professionals; poor and vulnerable groups	Nationwide

Table I.6.b: ASIAN DEVELOPMENT BANK - Detailed Ongoing Activities 2002

Approval - Closing Dates	Original Loan Amount (US\$ millions)	Loan	Objectives and Scope	Target Population	Geographic area
12/00 - 3/06	65.0	INO 34007-01 (ADF): Health and Nutrition Sector Development Program	The immediate project objective is to avoid the breakdown in the delivery of health services in the project area that may be caused by the rapid implementation of decentralization. Technical support provided under the project will build the local capacity to plan and to manage health services. In the second phase the project will help districts and provinces implement appropriate health sector reforms and support investments to better address the needs of the poor and vulnerable groups and improve services quality, efficiency and effectiveness. Activities are grouped into four components: (i) advocacy and capacity building; (ii) adapting health services to local needs through appropriate health sector reforms; (iii) investments for health and family planning; and (iv) project management including implementation, monitoring and evaluation.	Health personnel and health professionals; poor and vulnerable groups	Aceh, Bali, Bengkulu, Central Sulawesi, North Sulawesi, Riau, Southeast Sulawesi
9/03 - 12/05	100 OCR: 64.8/ADF: 35.2	INO 34149-01: Second Decentralized Health Services	The goal of the project is to improve the health status of the people by enhancing service coverage, quality, and utilization of health facilities. The objective is to assist local governments, health professionals and communities identify health needs and priorities, developing locally appropriate solutions and improving health services quality. The project will comprise capacity building and training activities, physical investments to improve service quality, and support locally adapted health sector reforms.	Health personnel and health professionals; poor and vulnerable groups	Bengkulu, Belitung, South Sumatra and Jambi, West, Central and South Kalimantan, and South Sulawesi

Table I.7: UNICEF - Detailed Ongoing Activities 2002

Start - End Dates	Total Commitment (US\$ millions)	Grant	Objectives and Scope	Target Population	Geographic area
2001-2005 (RR)	28.6	UNICEF country program - all components			Banten, East Java, Central Java, West Java, Maluku, East Nusa Tenggara (NTB), West Nusa Tenggara (NTT), Papua, South Sulawesi
2002 (OR)	17.0	UNICEF country program - all components			
			Support for Immunization : vaccine procurement fro National Immunization Day; support to GOI in the preparation od national workplan and budget for Maternal and Neonatal Tetanus Elimination (in collaboration with WHO); measles school catch-up project (CDC Atalanta funds); cold chain (CIDA donation); procurement of auto-disable syringes (with GAVI funds).	Women and children under 5	
		RR UNICEF; OR: AusAID	Integrated Management of Childhood Illness (IMCI) : UNICEF is supporting the Gvt. In the printing, advocacy, training and supplies needed for midwives in Maluku and Papua and in Central Java (Brebes). WHO is providing technical asistance.	Children under 5.	Malaku, Papua, Central Java (Brebes)
		OR: AusAID	Safe Motherhood : the 4 major components are (i) capacity building of essential obstetric care services; (ii) capacity building of community midwives in the villages; (iii) capacity building of communities; and gvt. capacity building (provincial and district teams)	Pregnant women and children under 5	
		OR: AusAID, USAID, Procter and Gamble	Growth Monitoring and Promotion : development of policies and guidelines and support for training at the district level.	Children under 5.	
		OR: CIDA; Japan National Committee for UNICEF; the Netherlands; USAID and the United States Fund for UNICEF	Control of Micronutrient deficiencies - Iodine deficiency disordres; vitamin A supplementation; food fortification	Children under 5.	
			HIV/AIDS : specific information for youth in and out of school; prevention of mother-to-child transmission (PMTCT); children and families living HIV/AIDS	Children and families living with HIV/AIDS	

Table I.8: UNFPA - Detailed Ongoing Activities 2002

Start - End Dates	Total Commitment (US\$ millions)	Grant	Objectives and Scope	Target Population	Geographic area
2001-2005	<p>28.0</p> <p>[RR: 21.0; OR: 7.0]</p> <p>21.0</p> <p>2.9</p> <p>3.5</p> <p>0.6</p>	<p>UNFPA Population Programme</p>	<p>Support of population programme over a 5-year period to assist the GOI in achieving its population and development goals.</p> <p>Reproductive health</p> <p>Population and development strategies</p> <p>Advocacy</p> <p>Programme coordination and assistance</p>		

Table I.9: WHO - Detailed Ongoing Activities 2002

Start - End Dates	Total Commitment 2002-2003 biennium (US\$ millions)	Areas of Work	Objectives and Scope	Target Population	Geographic area
	5.7	Communicable diseases	Communicable disease surveillance Communicable disease prevention, eradication and control Malaria Tuberculosis		
	0.04				
	0.43				
	0.96				
	4.27				
	0.9	NCD and mental health	Surveillance, prevention and management of NCD Tobacco Health promotion Disability/injury prevention and rehabilitation Mental health and substance abuse		
	0.16				
	0.19				
	0.45				
	0.05				
	0.09				
	2.8	Family and community health	Child and adolescent health Research program and development in reproductive health Making pregnancy safer Women's health HIV/AIDS		
	0.82				
	0.09				
	0.84				
	0.05				
	0.68				
	2.6	Sustainable development and healthy environments	Health and environment Food safety Emergency preparedness and response		
	0.53				
	0.03				
	1.99				
	7.6	Health technology and pharmaceuticals	Essential medicines: access, quality, and rational use Immunization and vaccine development* Blood safety and clinical technology		
	0.45				
	7.04				
	0.06				
	3.2	Evidence and information for policy	Evidence for health policy Research, policy and promotion Organization of health services		
	0.47				
	1.01				
	2.2	Country Office			
Total (biennium)	45.7				

Table I.10: Bill and Melinda Gates Foundation and Global Alliance for Vaccine and Immunization - Detailed Ongoing Activities 2002

Start - End Dates	Total Commitment (US\$ millions)	Grant	Objectives and Scope	Population targeted	Geographic area
<u>Bill and Melinda Gates Foundation</u>					
7/01-7/06	4.5	Reproductive and Child Health Grant (DKT Internatonal)	Reduce fertility by increasing access to high quality, low-prices contraceptives for lower-income populations in the major urban areas of Indonesia	Low income populations	Major urban areas of Indonesia
<u>GAVI (1)</u>					
1/02-1/07	16.0	Immunization services support	The proposed strategy includes 3 components: 1. re-empoeer or revitalize the existing procedure and systems that once had been proven to be effective to improve coverage; 2. explore scientific strategies or activities based on local specific problems; 3. follow the principles of autonomy and decentralization.	Infants and children under 5	Nationwide
	10.7	Injection safety support	GAVI funds the procurement of AD syringes for all immunizations	Children under 5, WCBA	
	13.2	New and underused vaccine support (hepB uniject)	The NVS (new vaccine support) is used to support the provision of the first dose of Hep B uniject, given as a birth dose, followed by a second and third dose. Activities include the development of training modules and "cascade" training.	Infants	
	0.1	Other support			
sub-total	40.1				

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SEARO

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Peggy Thorpe, First Secretary (Development)

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