

AID EFFECTIVENESS IN THE INDONESIAN AIDS RESPONSE

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Indonesia**

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Aid Effectiveness in the Indonesian AIDS Response

A thesis submitted in partial fulfillment of the requirement for the degree of
Master of Public Health

By

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Acronyms and abbreviations

ADB	asian development bank
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral medicines
AusAID	australian agency for international development
BAPPENAS	national planning and development board
BAPPEDA	provincial planning and development board
BPS	central bureau of statistic
BSS	behavioural surveillance survey
CCA	common country assessment
CCM	country coordinating mechanism
CST	care, support and treatment
CSW	commercial sex worker
CDC	center for disease control
DAC	district aids commission
DKT	condom social marketing agency
DFID	UK department for international development
ECOSOC	economic and social council
FHI	Family Health International
FSW	female sex worker
GFATM	global fund to fight aids, tb & malaria
GNI	gross national income
GOI	government of indonesia
GTT	global task team
Inpres	Presidential Instruction
HLF	high level forum
HIV	human immunodeficiency virus
IBBS	integrated bio-behavioural surveillance
IDR	indonesian rupiah
IDU	injecting drug user
IEC	information, education and communication
IHPCP	indonesia hiv prevention and care project
ILO	international labour office
IMAI	integrated management of adolescent and adult illness
IPF	indonesian partnership fund
Kepres	presidential regulation
KfW	germany development agency
MoH	ministry of health
MDG	millennium development goals
M&E	monitoring & evaluation
MSM	men having sex with men
NAC	national aids commission
NAF	national action framework
NAS	national aids strategy

NGO	nongovernmental organization
OECD	organization for economic development and cooperation
OI	opportunistic infection
PAC	provincial aids commission
PerPres	Presidential Regulation
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PR	principle recipient
PSG	programme steering group
RPJP	long term development plan
RPJM	medium term development plan
SCMS	supply chain management system
STI	sexually transmitted infection
TWG	technical working group
FSW	female sex worker
UN	united nations
UNAIDS	joint united nations programme on aids
UNDAF	united nation development assistance framework
UNDP	united nation development programme
UNJAP	united nation joint action plan
UNFPA	united nation population fund
UNGASS	united nation general assembly special session
UNICEF	United Nations Children Fund
UNESCO	united nation education, scientific and cultural organization
USAID	united states
USD	united states dollar
UU	government regulation
VCT	voluntary counseling and testing
WHO	world health organization
WB	world bank

ABSTRACT

Title:

A Review of AIDS Effectiveness in the Indonesian AIDS Response
With a selected case study on Papua province

As promised in the Millennium Development Goals, stopping new HIV infections and reversing the AIDS epidemic are two major targets of the Indonesian AIDS response. Ensuring aid effectiveness is a crucial issues considering that more than 70% of current resources for the AIDS response are in the form of foreign aid. This paper would like to review to what extent the government of Indonesia and its donors have made efforts in improving aid effectiveness. As a case study, the paper will review progress made in Papua province.

This paper is a policy research, based on a review of available literature on aid effectiveness, donors' policy and programme documents and national and local AIDS policy and programme documents. The author is using principles in Paris Declaration to generate an assessment framework for the purpose of this paper.

Based on the study, the main challenges in improving aid effectiveness in the Indonesian AIDS response are defining the most ideal model for the National AIDS Commission to provide a more effective management of the AIDS response in Indonesia; defining and strengthening the national management system for AIDS response and mobilize coordinated support from donors; defining comparative advantage, clarifying division of labors and developing a complementarity plan. To address these challenges, the government of Indonesia must demonstrate its leadership for AIDS by taking the lead and translate it into the necessary actions.

Key Words: aid effectiveness, aids response

Introduction

I have been working for the Indonesian AIDS response since 2002, starting with UNAIDS Secretariat in Indonesia as a Communication Associate and then latter with the Indonesian AIDS Commission as a Resource Mobilization Officer. The role of the latter position is to strengthen relations between National AIDS Commission (NAC) and its donors and to provide support to the Indonesian Partnership Fund (IPF) for AIDS, one of the funding mechanisms created to finance the implementation of the National AIDS Strategy 2003 - 2007. This was how my interest started on the subject of aid effectiveness in the national AIDS response.

Making aid delivery more effective is a major public health challenge. Resources for promoting public health are scarce. It is critical to ensure that when they are utilized, they are truly being directed to produce the desired health outcome. In the AIDS response, there has been a dramatic increase of resources over the past decades. Yet, progress to stop and reverse the AIDS epidemic is still far within reach. Have resources been invested strategically in the AIDS response? There are multiple factors to assess to be able to answer this question. One important factor is whether the choice of intervention is relevant to the local context of the AIDS epidemic and whether it is the most cost-effective intervention among other similar approach. Critically important is also to assess whether the delivery of aid to finance the chosen interventions has been made in a way that ensure timely and sustainable response. Among others, this means ensuring ownership and localized response, and no unnecessary delays due to multiple bureaucracies at various administrative levels.

The Paris Declaration on Aid Effectiveness and the GTT Recommendations on improving aid delivery in the global AIDS response have been monumental in setting the goals toward improving aid delivery, especially for the AIDS response. Taking the context of the Indonesian AIDS response, this paper would like to review to what extent the recipient-country and its donor-countries have progressed with their commitments. As a case study, the paper will review progress made in the province of Papua.

This paper will asses and analyze the progress made by major donors toward improving aid delivery in the Indonesian AIDS response; assess and analyze the progress made by the national and local AIDS commissions toward improving aid delivery in Papua; and formulate policy recommendations for the Indonesian National AIDS Commission toward improving aid delivery in the national AIDS response. Results from this study can be used a starting point to dialogue about developing a more concrete plan on improving aid delivery in the national AIDS response that respect and follow commitments made in the Paris Declaration on Aid Effectiveness and recommendations made by the Global Task team on AIDS.

Chapter 1: Country Background

1.1 Profile: Republic of Indonesia

Total Indonesian population in 2000 national census was 206million (BPS, 2000). This makes Indonesia the fourth most populous in the world. After a long struggle to recover from its devastating economic crisis in 1997, Indonesia is now transitioning into a low-middle income country. While the average GNI is US \$1420 per capita, the World Bank estimates that around 18% of the total population is still living under poverty line (World Bank, 2006).

Administratively, the country is divided in to 33 provinces. Each province is further divided into districts and municipalities. At this level, another subdivision is made into subdistricts, and again into village groupings. Following the implementation of decentralization policy 2001, the districts and municipalities have become the key administrative units, responsible for providing most government services (UU 22/1999).

Indonesia is currently implementing its medium term development plan (RPJM) 2004 – 2009 (Perpres 07/2005), which is the first phase implementation of the long-term national development plan (RPJP) 2005 – 2025 (UU 17/2007). The National Development Planning Board (BAPPENAS) under the State Ministry for National Development is in charge of the development of the plan that sets national programme priorities and resource allocation for the different sectoral ministries and regional administrations.

In every province, the provincial development board (BAPPEDA) is in charge of the provincial development plan following the direction set in the national development plan. Since the implementation of decentralization policy in 2001, the link of the national and provincial planning is no longer a hierarchical procedure but rather a consultative process. The provinces and districts are no longer dependant on the budget allocated from the central government and are responsible for mobilizing resources to finance their own development priorities (UU 22/1999).

1.2 Indonesia: Health Profile

According to WHO SEARO's country profile, Indonesians' life expectancy at birth is 69 years old. Infant mortality (IMR) has decreased from 68 per 1,000 live births between 1986 and 1991, to 32 per 1,000 live births in 2005. The major cause of morbidity and mortality is communicable diseases; which among others include TB and Malaria. Indonesia ranks third in global burden of TB fatalities. While HIV prevalence is relatively low at 0.1 among adult population, increasing HIV epidemics are found concentrated in some key populations. Periodically, dengue fever can come in epidemic proportions. In the wave of avian influenza in Asia, Indonesia ranked first in case fatalities that accounts for almost 75% of the cases in 2006. Coverage of health services is relatively adequate across the country, with one public health centre (Puskesmas) for every 30 000 people on average. However, development and maintenance of public infrastructure are not always fairly distributed across the country. In many underdeveloped parts of Indonesia, access to health services is still limited. Indonesia is also lacking an adequate number of health personnel (WHO SEARO, 2005).

Chapter 2: Problem Statement

2.1. Toward Improving Global Aid Effectiveness

Vital to achieving the Millennium Development Goals, there is a general consensus among the donor community to align and harmonize aid disbursement, reporting and other practices among donors. According to the Aid Harmonization & Alignment website, currently there are more than 60,000 development aid projects in different parts of the world funded by over 90 official aid agencies (Aid Harmonization & Alignment, 2008).

Receiving countries face enormous challenges to follow with various different procedures as conditions of receiving aid. This process often consumes more time than the actually delivering the work to achieve development impact.

The Rome Declaration on Harmonization in February 2003 was one of the visible commitments made to improve aid effectiveness by committing to ensure that efforts are geared to adapt donors' assistance to the country context and to align them to the development priorities of partner-country (Rome HLF, 2003). A survey on progress on the Rome Declaration was made as a follow-up and was presented in a High Level Forum in Paris in 2005. It was then agreed that a set of recommendations to proceed with more concrete actions in improving aid effectiveness had to be made (Paris HLF, 2005). The Paris Declaration on Aid Effectiveness was adopted with binding agreement on twelve indicators of progress and targets (Annex 5). The five main principles on aid effectiveness as outlined in the Paris Declaration are:

Paris Declaration on Aid Effectiveness		
1	Ownership	<i>Developing countries exercise leadership over their development policies and plans</i>
2	Alignment	<i>Donors base their support on countries' development strategies and systems</i>
3	Harmonization	<i>Donors coordinate their activities and minimize the cost of delivering aid</i>
4	Managing for results	<i>Developing countries and donors orient their activities to achieve the desired results</i>
5	Mutual Accountability	<i>Donors and developing countries are accountable to each other for progress in managing aid better and in achieving development results</i>

Figure 1: Paris Declaration of Commitment on Aid Effectiveness

Source: Paris High Level Forum on Aid Effectiveness, 2005

2.2. Aid Effectiveness in the Global AIDS Response

In the global AIDS response, improving aid effectiveness is also becoming an increasingly critical issue. According to UNAIDS, global AIDS funding has dramatically increased in the last decade. In 1996, only \$260 million was available. In 2007, the size has grown to \$10 billion - an almost forty fold increase. This is due to the development of new international funding initiatives and mechanisms, such as the Global Fund for AIDS, TB & Malaria (GFATM), the World Bank's Global AIDS Programme and the US President's Emergency Plan for AIDS Relief (PEPFAR). (Kates J, 2006)

As investment grows, many developing countries are experiencing difficulties in managing incoming AIDS fund from different partners to ensure effective allocation of resources for better delivery of AIDS treatment and HIV prevention services to communities.

In 2003, UNAIDS introduced the "Three Ones" principles: One national AIDS Action Framework; One National AIDS Coordinating Authority; and One agreed country-level Monitoring and Evaluation System -- as a prerequisite to achieving the most effective and efficient use of resources, and to ensure rapid action and results-based management (UNAIDS, 2003).

This was followed by the formation of a Global Task Team (GTT) on improving coordination among multilateral institutions and international donors to further strengthen the AIDS response in countries. GTT focuses on how the multilateral system can streamline, simplify and further harmonize procedures and practices to improve the effectiveness of country-led responses and reduce the burden placed on countries (UNAIDS, 2005c).

2.3. Reality of Aid Delivery in the Indonesian AIDS Response

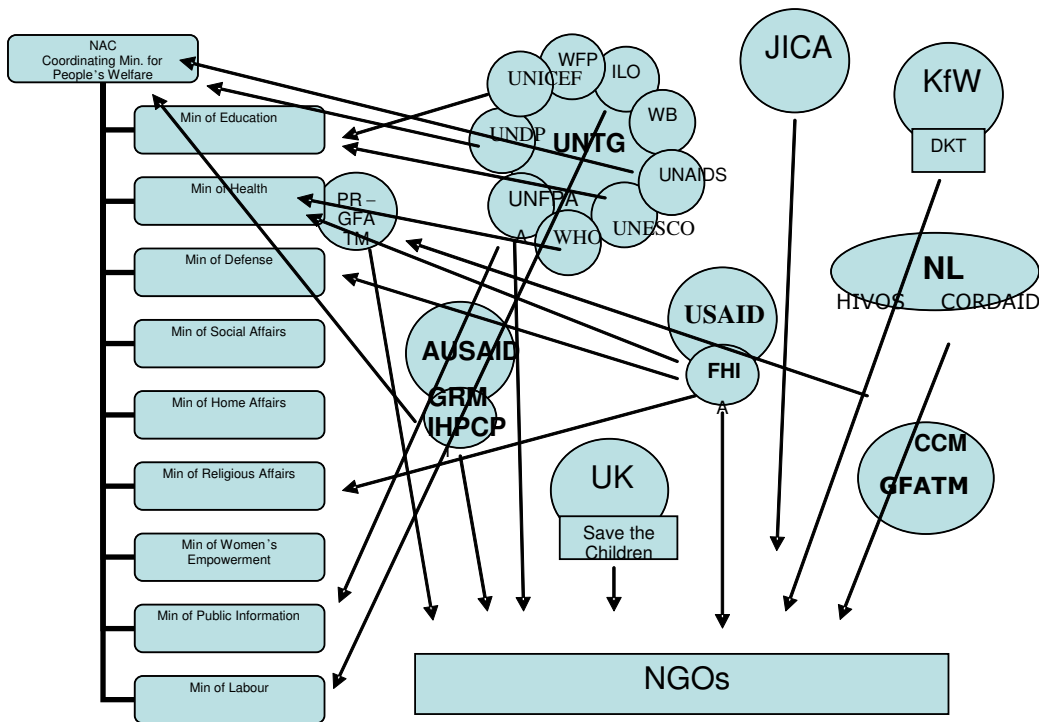


Figure 2: An illustration of aid delivery in Indonesian AIDS Response

While the general dependency to donor funding in the health sector has decreased, the Indonesian AIDS response has always been donor dependent from the onset of the AIDS epidemic. Percentage of external resources for health was at its highest during the economic crisis (1998-2000), accounted for 10-12% from the total proportion of health sector resources. This has started to steadily decrease from 2004 at 4.4% and eventually at 2.3% in 2006 (WHO, 2008). However, during this period, more than 70% of current resources for the AIDS response are in the form of foreign aid (NAC, 2007a).

Major donors in the Indonesian AIDS response include the Global Fund to Combat AIDS, TB and Malaria (GFATM), the United Kingdom (DFID), United States Government (USAID), Australian government (AusAID), Germany (KfW), the Netherlands, Japan (JICA), European Union (EU) and the UN Specialized Agencies (UNAIDS, UNDP, UNICEF, UNFPA, WHO, etc). As seen in Figure 2, each comes with a different approach toward the AIDS epidemic in Indonesia. Overlaps are rampant at the operational level where different projects are delivering similar services and targeting the same population. Thus, making aid delivery more effective to produce the desired impact to the epidemic is critical especially.

There have been efforts aimed at harmonizing donor supports to increase collaboration and reduce overlaps. However, there has been no systematical mechanism for donor coordination and harmonization developed to sustain

the process. Most of the initiatives taken were donor-driven. Most donors providing support to the Indonesian AIDS response are also signatories of the Paris Declaration on Aid Effectiveness. They also conform to the GTT Recommendations on improving aid delivery in the global AIDS response.

In the spirit of harmonization and alignment, UNAIDS has developed a Country Harmonization and Alignment Tool (CHAT) to help countries map their stakeholders and assess their engagement in the national AIDS response (UNAIDS, 2007). Indonesia is one of the selected countries to pilot this tool. The result highlighted that some key obstacles to alignment, harmonization and participation in Indonesia are insufficient mechanism for coordination and the perceived weakness of the NAC (Lubis, 2006).

While Indonesia has signed both, the commitment on Millennium Development Goals and the UNGASS Declaration of Commitments, to stop new HIV infections and reversing the AIDS epidemic, the commitment to strengthening national capacity to lead and coordinate the national response seemed lacking.

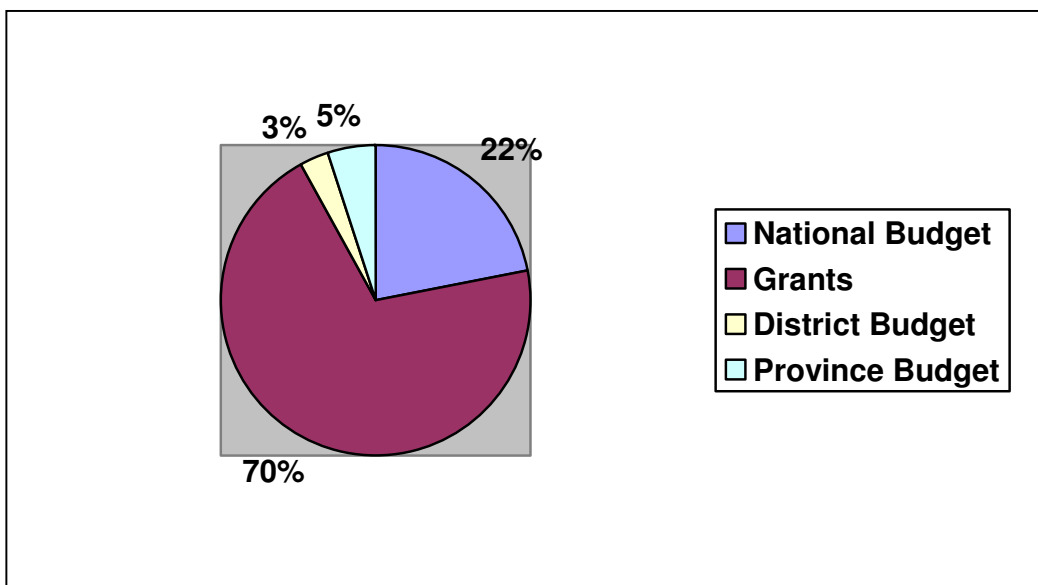


Figure 3: AIDS budget by source of funding (2006)

Source: Mboi N, 2007. Presentation to AIDS Partnership Forum. Jakarta: NAC

2.3.1 Objective

Based on the commitment made by donors and their partner countries in the Paris Declaration on Aid Effectiveness, this paper would like to review the progress made toward making aid delivery more effective in the Indonesian AIDS Response. As a case study, the paper will review progress made in Papua province.

2.3.2 Specific objectives:

- (1) Assess and analyze the progress made by the government of Indonesia and its major donors toward improving aid delivery in the Indonesian AIDS response
- (2) Assess and analyze the progress made by the provincial government of Papua and its donors toward improving aid delivery in the specific case of Papua
- (3) Formulate policy recommendations for the Indonesian NAC toward improving aid delivery in the national AIDS response

2.3.3 Target

The primary target of this paper is the NAC as my employer as well as the donor agencies supporting the Indonesian AIDS Response, the provincial and district AIDS Commissions and other national partners.

Results from this study can be used a starting point to dialogue about developing a more concrete plan on improving aid delivery in the national AIDS response that respect and follow commitments made in the Paris Declaration on Aid Effectiveness and recommendations made by the Global Task team on AIDS.

2.3.5 Methodology

Literature Review

This paper is a policy research, based on a review of available literature on aid effectiveness, universally and specifically within the global AIDS response.

Policy Review

The paper reviews national and local AIDS policy and programme documents in Indonesia. The paper also reviews donors' policy and programme documents on AIDS programming and funding practices both at global and country level. As appropriate, interviews were conducted with key people representing these organizations to generate more information for analysis. The author also drew from her personal involvement in the Indonesian AIDS response.

Case Study

As a case study, this paper reviews the progress made toward improving aid effectiveness in Papua province. Papua is selected based on the following criteria: Size of the epidemic in the region; Level of response by the local government; Number and combination of donors working in the area.

This is also a specific recommendation made in the result of CHAT survey in Indonesia. Papua is one of two provinces in Tanah Papua, an island shared by Indonesian with Papua New Guinea. Papua represents the highest HIV epidemic in eastern Indonesia. Most major donors are working on AIDS in Papua, including USAID, AusAID, IPF, GFATM and the UN Agencies.

Online literature search was made using search engine of Google, PubMed, UNAIDS, OECD, World Bank, WHO, UNDP, DFID, USAID, AUSAID, GFATM and the Indonesian NAC.

Offline literature search for printed published documents without online version was made using emails to relevant institutions. Other data sources include interviews with relevant institutions. These institutions are among others; the Indonesian NAC, provincial AIDS Commissions in Papua, as well as relevant donor agencies and or their implementing partners.

Key words used; national AIDS response, local AIDS response, AIDS strategy, universal access, aid effectiveness, aid management, aid architecture, aid delivery, donor harmonization, donor alignment, national ownership, mutual accountability, result-based management, target, indicator, Paris Declaration, Rome Declaration, Global Task Team, Three Ones, monitoring & evaluation.

2.3.6. Framework of Analysis

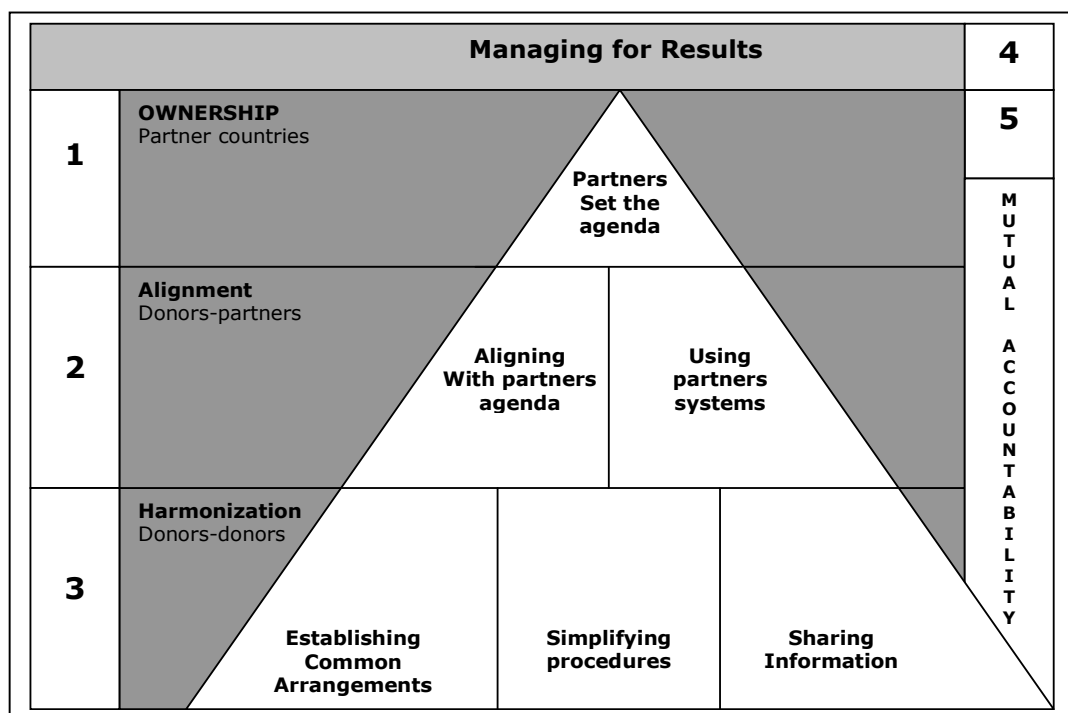


Figure 4: The Pyramid of Aid Effectiveness

Source: Organization for Economic Co-operation and Development (OECD), 2006.

The author is using principles in Paris Declaration on Aid Effectiveness to generate an assessment framework for the purpose of this paper. This framework was first used to assess progress made towards Rome Declaration on Harmonization. The subsequent report on progress toward Paris

Declaration has adapted the framework for its assessment and included Mutual Accountability within the framework.

The framework is mainly built on three broad areas where managing for result and mutual accountability are integrated components across all three. The three areas are:

Ownership - To what extent the recipient country is able to lead and set the development agenda

Alignment - To what extent the recipient country is able to provide a solid national development plan where donors can align themselves to and to what extent the donor countries are doing so

Harmonization - To what extent the donor countries are harmonizing their efforts to support the development priorities of the recipient country

Managing for results and Mutual accountability focus on the extent to which joint efforts by recipient-country and donor-countries are evidence-informed, costed and operationalize with clear targets and can be progressively be monitored against a set of indicators. This also entails how recipient-country and donor-countries are accountable for the results promised.

The pyramid can be interpreted in two approaches:

- Top-down - this is how an ideal setting should be. Recipient country begins with leading and setting the development priorities. Donor countries align their support to the priorities and use existing country system to channel their support. It finishes with a complementary action by donors in increasing shared effectiveness for aid delivery by establishing common arrangements, simplifying procedures, and sharing information.
- Bottom-up - this is how the reality of aid delivery in many countries. Donor-countries provide development aid to recipient country. Discussion emerged among donor-countries on how shared effectiveness on delivering aid can be achieved. Donor-countries provide support for one common national development plan to align them selves with. The objective is to progress upward where the recipient-country eventually takes the lead.

For the purpose of this paper, a set of questions based on this framework has been developed to guide the flow of analysis (Annex 2). The author will attempt to answer the questions through review of available literature, review of national policy and programme documents, review of donors' policy and programme documents, and interviews with key people representing these organizations as appropriate. The author will also draw from her personal involvement in the Indonesian AIDS response.

2.3.7 Scope of paper and limitation

This paper is limited to review progress made toward improving aid delivery in the Indonesian AIDS response during the implementation period of the Indonesian NAS 2003 to 2007.

The author is using principles in Paris Declaration to generate an assessment framework for the purpose of this paper. This paper is not trying to measure general country progress in the implementation of the Paris Declaration.

While Papua has been chosen as a case study, the AIDS epidemic Papua is a completely different epidemic from the rest of the country. Thus, the case study cannot be generalized to reflect the national situation.

Some of the documents for review are published documents but without proper electronic documentation. The author completely relies on the willingness of the owner of these documents to share them via emails. All interviews will be conducted by email and or phone calls. The author completely relies on the willingness of the respondents to answer the questions.

Chapter 3: Review of Indonesian AIDS Epidemic and Response

3.1 AIDS Epidemic in Indonesia

According to the Indonesian Ministry of Health (MOH), the national HIV prevalence in Indonesia among its adult population is currently at 0.1 percent and about 169,000 to 216,000 people are currently living with HIV in Indonesia (BPS, 2006).

In the first decade since the first AIDS case was reported in Indonesia (1987), HIV epidemic has developed gradually and was very much concentrated within high risk populations, such as; sex workers (SW), men who have sex with men (MSM) and transvestites (*waria*). However, in its second decade, Indonesia is suddenly seeing a rapid increase of HIV infections. In between 2002 to 2006, MOH recorded 2873 new reported AIDS cases or doubled the number found in the first seventeen years of the epidemic. By the same period of time, all 33 provinces of Indonesia have also reported HIV and AIDS cases (MOH, 2006).

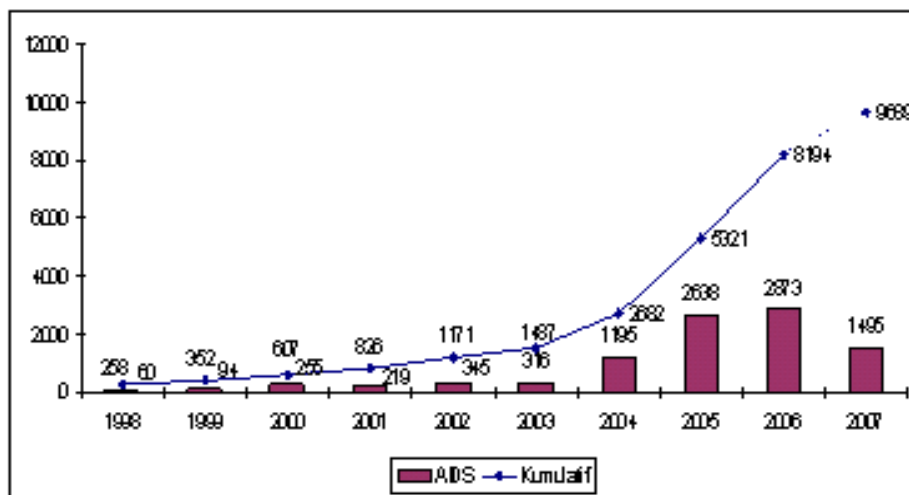


Figure 5: Distribution of reported AIDS cases 1998 - 2007

Source: National AIDS Commission (NAC), 2007.

Apart from the steadily increasing HIV infections through unprotected sex, this is mainly due to a sharp increase of HIV infections found among injecting drug users. The regular national estimation survey carried out by MOH shows that HIV prevalence among injecting drug users has alarmingly risen from 26 percent (BPS, 2002) to 41 percent (BPS, 2006).

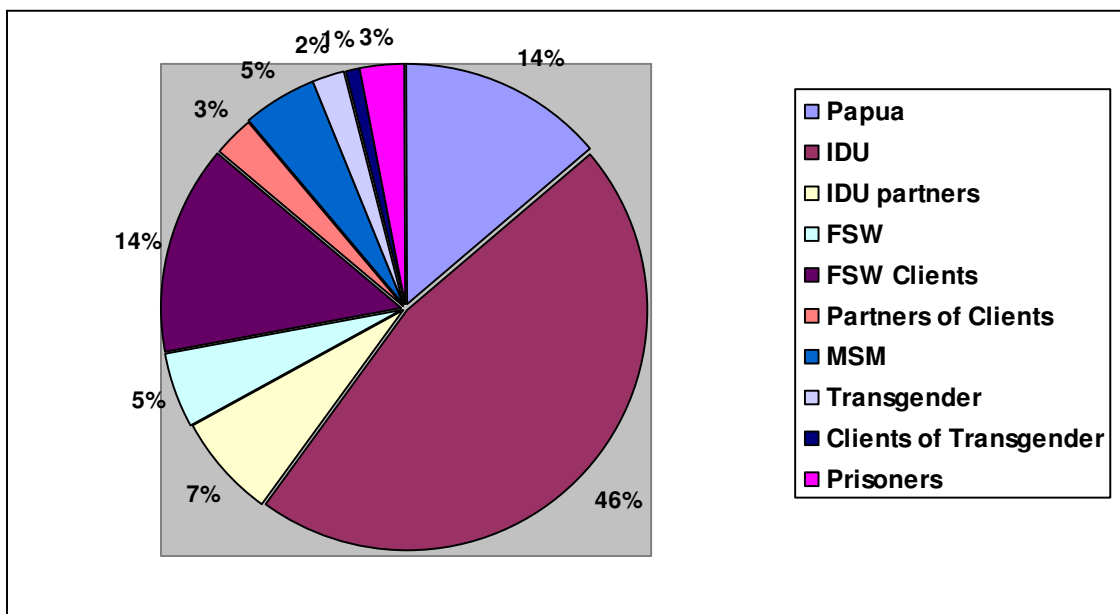


Figure 6: Distribution of people living with HIV 2006

Source: National AIDS Commission (NAC), 2007c.

If Indonesia does not significantly scale-up its response to AIDS soon, epidemiologists predict that there would be 400,000 HIV infections cases and 100,000 AIDS related deaths by the year 2010. While by 2015, there would be an explosion of 1,000,000 HIV infections and 350,000 AIDS related deaths (NAC, 2007b).

3.2 AIDS Response in Indonesia

3.2.1 Prevention

AIDS prevention is largely done through the provision of Information, Education and Communication (IEC) activities for behaviour change targeting most at risk population. Condom promotion and harm reduction are two major components of the prevention activities. The targeted beneficiaries are mostly sex workers and their clients / partners, men who have sex with men (MSM) and their clients / partners, injecting drug users (IDUs) and their partners, as well as people living with HIV (PLHIV) and their partners. Prevention activities are prioritized in 100 districts and municipalities across 22 provinces (NAC, 2007c). In selected provinces, education on AIDS prevention has been included in the curriculum for life skill education.

In its NCAP 2007-2010, the NAC reported that 290 Voluntary Counseling and Testing (VCT) centers have been made available nation wide in 118 cities and district levels (NAC, 2007c). The services are not only provided by the government but also by private health facilities and non-governmental organizations (NGOs). Though the coverage has increased significantly, it has not met the level it requires to match the speed of the epidemic. For

example, outreach to injecting drug users (IDU) is only able to cover less than 7% of the targeted population (NAC, 2007a).

The Ministry of Health regularly conducts HIV surveillance to monitor the spread and trend of the epidemics across the country and among key population. The first integrated bio-behavioral survey was conducted in Papua in 2006 (NAC, 2007a).

3.2.2 Care, support and treatment for people living with HIV:

The 3by5 commitment was monumental in accelerating the national response to care, support and treatment for people living with HIV (PLHIV). In 2003, WHO estimated 11,500 PLHIV were in need of treatment in Indonesia but MOH reported less than 3000 people were on treatment (WHO, 2005). By end of 2006, more than 7000 people in need of treatment are already on ART. To date, around 153 hospitals have been trained to provide treatment services in 118 cities and district levels. There are 115 support groups for people living with HIV in more than 70 districts and cities across the country that provide support to more than 5000 PLHIV (NAC, 2007a).

Though number of people on treatment has increased, treatment for opportunistic infections and provision of second line ARV are not parts of the scheme. Stigma and discrimination also hamper the progress for prevention, care and treatment as people who are most at risk, refrain themselves from getting themselves tested (WHO, 2007).

3.2.3 Impact Mitigation

Little has been done in this area of impact mitigation. UNICEF has started a campaign to protect children from HIV and AIDS. It includes social protection programme for children orphaned by AIDS. ILO and UNDP has jointly organized Start Your Business project, aimed at providing entrepreneurial skills for people living with HIV (UN, 2003).

3.2.4 National and international commitments:

Period: 1988 – 2000

In Indonesia, the first National AIDS Committee was established under the Ministry of Health. Supported by WHO Global AIDS Programme, it was established in 1988 and it included multisectoral and NGO representatives (NAC, 2003a). However, increasing global attention to the spread and the fatality of the epidemic has led to the internationally-recommended establishment of a multisectoral National AIDS Commission (NAC), independent from the health sector (Putzel, 2004). The commission was established under a presidential decree in 1994. The Coordinating Minister for People's Welfare was appointed Chair of NAC while the Minister of Health was one of the Vice Chairs. Members of the NAC were mostly ministerial cabinet members and there were no representation of civil society. The decree

stipulated that the NAC was established to provide national leadership role and a multisectoral approach in the Indonesian AIDS response (Keppres, 1994). Following the decree, NAC developed the first National AIDS Strategy (NAS) and a 5-year Programme Plan for AIDS Prevention and Control (1995-2000) as part of the 6th National Development Plan. Due to the wave of Asian economic crisis that hit Indonesia in 1997, the plan failed to receive priority funding from the government. The government completely relied on major AIDS donors such as USAID and AusAID, to fund and implement the national strategy (NAC, 2007b).

Period: 2001 – 2004

In 2001, Indonesia signed the Declaration of Commitment of the UN General Assembly Special Session (UNGASS) on AIDS in June 2001. Signed by the Ministry of Health, the country committed itself to the UNGASS targets and indicators set for 2010. Subsequently, the President called for two special cabinet meetings on AIDS in 2002. Among others, two major results were the inclusion of AIDS as a national development priority with annual allocation of funding and the call for the development of the National AIDS Strategy (NAS) 2003-2007 to guide the response (NAS, 2007b). With support from major international partners, the NAS (2003-2007) was developed and launched.

An accelerated response in 6 Indonesian provinces with the highest HIV and AIDS prevalence levels began when the Sentani Commitment was signed in January 2004. Sentani Commitment was a high level leadership meeting of governors from the 6 provinces taking place by Sentani Lake region in Papua. The provinces were DKI Jakarta, Riau, Bali, East Java, West Java and Papua. The commitment bound the 6 provinces into specific targets that include increasing coverage for condom promotion, harm reduction, ARV treatment and creating a more enabling policy environment for the response (NAC, 2004).

Period: 2005 -2007

When the National Action Framework (NAF) 2005-2007 was developed to operationalize NAS 2003 -2007, an accelerated response has since been expanded to another 8 provinces. In year 2005, an accelerated program in 100 districts/municipalities in 22 provinces was launched.

The NAF (2005-2007) was developed after DFID signaled an interest to support the Indonesian AIDS response through a joint approach. With DFID support, a type of multi donor trust fund was established in the form of the Indonesian Partnership Fund (IPF) for AIDS to finance the implementation of NAS (2003 – 2007). For this purpose, the NAF 2005-2007 was developed with support from UNDP and UNAIDS. NAF was made to cost and operationalize NAS with clear targets and indicators. A Programme Steering Group (PSG) was established to provide governance to the implementation of

NAF. The Coordinating Ministry for People’s Welfare as chair of NAC assumed chairmanship of the PSG. Members of PSG included other donor agencies and civil society representatives (NAC, 2005b).

The implementation of NAF required a strong leadership of NAC through the PSG. Thus, there was a need to strengthen the capacity of NAC to do so. One of the primary objectives of NAF was to support the adoption of Three Ones principle in the Indonesian AIDS response: One national AIDS Action Framework; One National AIDS Coordinating Authority; and One agreed country-level Monitoring and Evaluation System (UNAIDS, 2003).

In 2006, the NAC was eventually reformed through a Presidential Regulation. The regulation stipulated that the NAC is now directly accountable to the President and is required to provide a quarterly report to the President. The NAC continues to be chaired by the Coordinating Minister of People’s Welfare, with two vice-chairpersons, the Minister of Health and the Minister of Home Affairs. The membership of the NAC is enlarged to 23, including 18 ministries and agencies, and five (5) non governmental organizations. The most important change from the previous NAC regulation was a clear stipulation of the appointment of a full time secretary to the NAC and the establishment of a dedicated NAC secretariat. It also instructed the establishments of provincial AIDS commissions (PACs) and district AIDS commissions (DACs). The financing of AIDS response should come from the State Budget at the national level and from the provincial / district / municipality level at the local level (PerPres, 2006).

Indeed, the government showed an increased response to AIDS in this period. The government budget for AIDS has doubled over the past few years, but most of the state funding for AIDS during 2003–2007 went to the health sector and the increase of overall state funding was far from matching the donor funding for AIDS (NAC, 2007a).

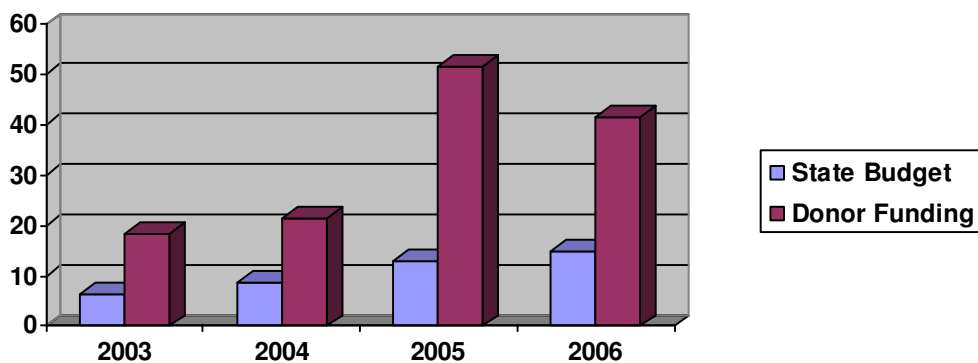


Figure 7: AIDS budget by source of funding (in USD millions)

Source: NAC, 2005 & NAC, 2007a

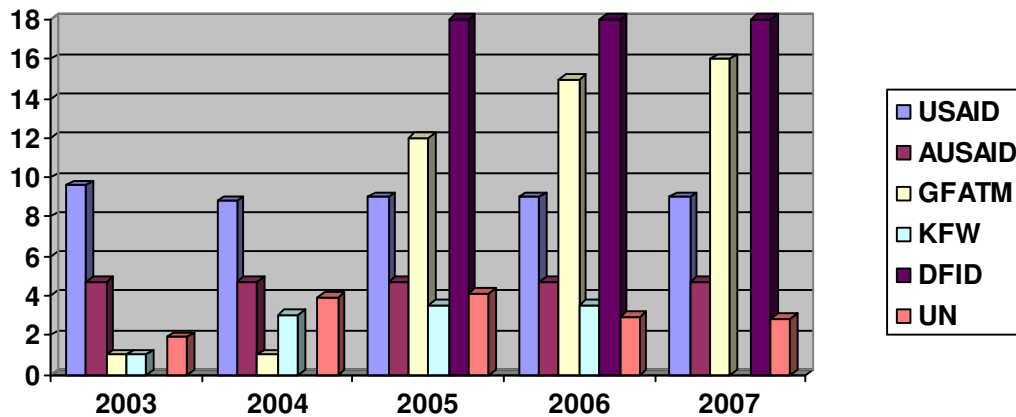


Figure 8: AIDS budget by source of foreign funding (in USD millions)

Source: NAC, 2003

This clearly reflects Indonesian dependency to donors for financing its AIDS response. This is in contrast with the decrease in general dependency to donor funding in the health sector. Percentage of external resources for health was at its highest during the economic crisis (1998-2000), accounted for 10-12% from the total proportion of health sector resources. This has started to steadily decrease from 2004 at 4.4% and eventually at 2.3% in 2006 (WHO, 2008). However, during this period, more than 70% of current resources for the AIDS response are in the form of foreign aid (NAC, 2007a).

Significant bilateral contributions are made by the governments of UK (DFID), USA (USAID), Australia (AusAID) and Germany (KfW). DFID's contribution constitutes over half of total bilateral supports. There are two major sources of multilateral contributions, the Global Fund for AIDS, TB and Malaria (GFATM) and the United Nations (UN). GFATM constitutes the biggest contribution made multilaterally. Combined together, they represent over 70% of the AIDS national spending (NAC, 2007a). However, as seen in Figure 8, their contributions to the Indonesian AIDS response over the past few years are quite volatile and unpredictable. Unless the government dramatically increases its AIDS budget to takeover at least half of the total resources needed, there is a huge doubt that the AIDS response in Indonesia is sustainable.

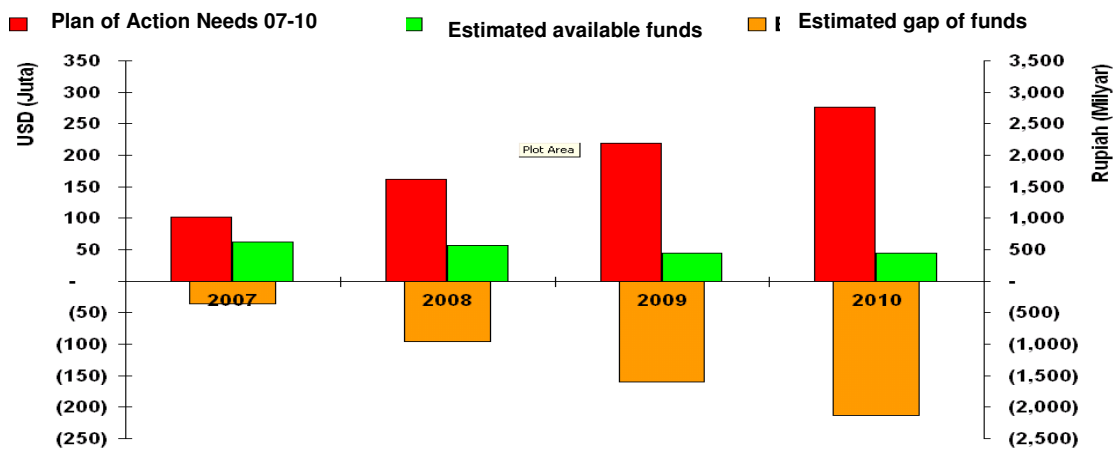


Figure 9: Analysis of funding needs 2007 – 2010 (in USD million & IDR billion)

Source: National AIDS Commission (NAC), 2007. National Action Plan 2007 – 2010. Jakarta: NAC

As per the commitments made in the Political Declaration on HIV and AIDS adopted in June 2006, Indonesia has developed the NAS 2007-2010 and it has been followed by the development of a National Costed Action Plan (NCAP) 2007-2010. To achieve the program targets set for the period 2007–2010, a total of US\$98million will be needed in 2007, rising to US \$260million in 2010 (NAC, 2007c). The NAC is spearheading efforts to mobilize adequate resources. While donor funding for AIDS response will continue but as seen in Figure 9, there will be an increasing gap between the resources available and the resources needed.

Chapter 4: Review of Aid Effectiveness in the Indonesian AIDS Response

4.1 Progress in improving ownership

In this section, the paper will review:

To what extent Indonesia has exercised its leadership to set the agenda of national AIDS response and to what extent the AIDS donors are supporting Indonesia in developing the leadership capacity to set the agenda of the national AIDS response (Annex 2).

During the first half of NAS 2003- 2007

By Presidential Decree in 1994, the NAC is the national authority mandated to lead, coordinate and manage the AIDS response (Keppres, 1994). After NAS 2003 – 2007 was launched, questions remained about who should follow with the development of operational/implementation plan, monitoring and evaluation, as well as alignment and harmonization (coordination) of all partners. NAC was present on paper but it had not established a secretariat with fulltime and dedicated staff. NAC board members never met. The secretariat role was delegated to the office of a senior civil servant in the ministry who also assumed other functional roles. The incumbent often changed following the movement of his or her career development.

Though NAC had been given the right level of authority, leadership was lacking as AIDS was not seen as a priority development issue. The questions about how much fund should be allocated and at what scale the implementation should be made, were completely left to the implementing partners, both national and international partners alike.

Based on the review of project documents, several donor agencies such as IHPCP - AusAID-funded project (GRM, 2002) and UNDP (UNDP, 1997) had seconded their staff to NAC in the expectation that it would strengthen the capacity of the NAC secretariat. However, it even furthered NAC dependency to the donor agencies. There was no-coordinated mechanism for providing capacity development for the NAC. Each partner provided capacity support for their own programme purpose.

During the second half of NAS 2003-2007

Most progress in improving ownership occurred during the second half of the implementation period of NAS 2003 – 2007 with the development of the NAF 2005 – 2007 and the establishment of the IPF to finance NAF. However, this was very much donor driven as NAF was developed as a pre-requisite of DFID funding to IPF.

One of the primary objectives of NAF was to support the adoption of Three Ones principle in the Indonesian AIDS response: One national AIDS Action

Framework; One National AIDS Coordinating Authority; and One agreed country-level Monitoring and Evaluation System (UNAIDS, 2003). One national action framework was achieved with the presence of NAS. NAF was to operationalize NAS with clear targets and indicators, which then became the foundation toward one-agreed national monitoring and evaluation system.

As for strengthening the adoption of one national AIDS coordinating authority, NAF was particularly geared to make the NAC Secretariat fully operational at national and all local levels functional in priority provinces and districts (NAC, 2005b). For this purpose, IPF made a grant for the NAC to build its capacity as the national coordinating body for AIDS in Indonesia. The government responded with reforming the NAC with Perpres 2006 that finally put a clear stipulation for the appointment of a full time secretary and a dedicated NAC secretariat. The grant was then used to support the development of a comprehensive work-plan for the NAC secretariat to run its mandate. The secretariat of the NAC is able to establish an office and recruit staffing, independent from the office of the Coordinating Ministry of People’s Welfare. The secretariat is also able to secure a budget line from the office of the Coordinating Minister for Peoples’ Welfare to access the state budget for its core activities. The secretariat has started to input its annual work-plan to the annual budget of the ministry (NAC, 2008).

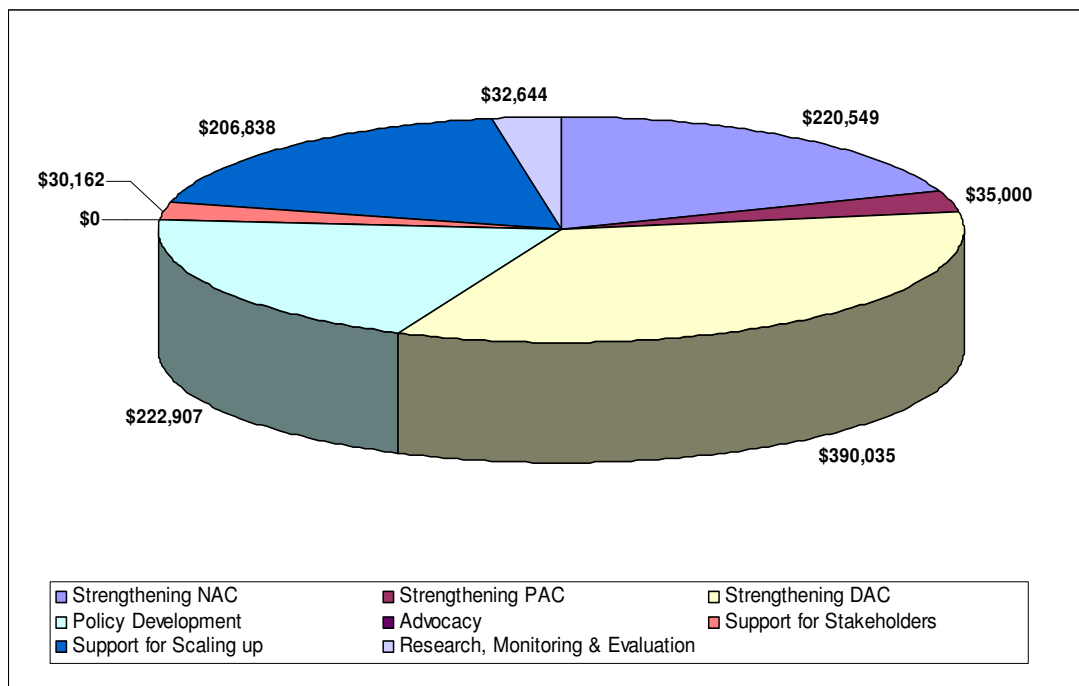


Figure 10: Distribution of budget across NAC’s workplan 2007 (USD)
Source: Mboi N, 2007

IPF grant was also used to support the operation for the secretariats of the provincial AIDS commissions (PACs) and district/municipal AIDS commissions (DACs) in 22 priority provinces and 100 district and municipalities. Previously, PACs and DACs were only present on paper by virtue of the Presidential Decree 1994 on the establishment of the NAC which also stipulated the establishment of PACs and DACs.

As part of the coordination role, NAC secretariat has developed a unified national M&E system to track progress in 100 priority districts and cities. The presence of full time secretariats of PACs and DACs were seen essential to coordinate the tracking process at the province and district level. The grant was utilized for financing the local secretariats' work-plans and recruitment of full time staff to support its daily operations (NAC, 2008).

In anticipating the completion of NAS 2003-2007, NAC secretariat also has developed the NAS 2007-2010 and it has been followed by the development of a National Costed Action Plan 2007-2010 (NAC, 2007c).

Challenges in improving ownership

- National commitment is still in question. While national AIDS response has been significantly scaled up in the past few years and Three Ones principles have been adopted, this is still largely due to a significant increase in the amount of external aid for AIDS. This is in contrast with the decrease in general dependency to donor funding in the health sector. While progress is made with the attempt to operationalize the national strategy with NAF, this was also due to external factor. NAF was a prerequisite of DFID support to IPF.
- Another challenge is sustaining the coordinating role at the national, provincial and district levels. Previously, NAC has very little influence over PACs and DACs. This was primarily due to the absence of clear structural lines between NAC and PACs / DACs. While Keppres 1994 outlined the establishment of NAC, PACs and DACs and their functions, it did not clearly define their responsibilities toward each other. Perpres 2006 does not make this structural line clearer either. But NAC has been able to use IPF grants to PACs and DACs as a way to exert accountability line. NAC has been able to control how IPF grants are being used across the priority districts and provinces. In this respect, coordination role has been strengthened. When IPF grant has run out, it is feared that coordination roles would weaken.
- With existing investment made to NAC, PACs & DACs, through IPF grants, questions remain about their sustainability. There is a transition made to gradually move operational budget of the NAC secretariat from using IPF grant to using state funding. The provincial /district AIDS commissions are being encouraged to do the same. However, the rate of success has not been very well distributed. Some have adopted very well while others see them as extra burden for the local budget.

- Capacity remains an issue. While NAC has been able to establish full time secretariat with dedicated staffing at the national, provincial and district levels, the distribution of capacity is still inadequate across all these level. International partners may sometimes provide technical assistance for capacity development. But overall, provision of capacity development is still done on an ad-hoc basis. There is no grand plan for capacity development to enable the country responds to the epidemic at the scale it needs.

4.2 Progress in improving alignment

In this section, the paper will review (Annex 2):

- To what extent Indonesia has delivered a comprehensive policy and plan to convince AIDS donors to align to its policy and plan and to what extent it has strengthen its system to convince AIDS donors to use its existing programme, administrative and financial management.
- To what extent AIDS donors are willing to align its programme support to the national policy and plan and to what extent they are willing to use the existing national programme, administrative and financial management in channeling their support

Alignment to country's policy and plan

National AIDS Strategy 2003-2007

With the presence of NAS (2003-2007), the government of Indonesia has claimed that it has provided a clear broad policy on AIDS for all its partners to align with. This included setting up broad policy on multisectoral response to AIDS. The launch of NAS was subsequently followed by the development of AIDS strategic plans by sectoral ministries such as the Ministry of Health (MoH), Ministry of Manpower and Transmigrations, Ministry of Education and Ministry of Social Affairs. Most of these sectoral strategies also offer a broad sectoral policy on AIDS. They also have started to input AIDS spending into their budget. However, NAC has no direct accountability lines to these ministries to be able to exert influence over the use of their resources. This is the only way NAC can ensure linkage of its national AIDS plan to the medium-term expenditure plan and the national medium-term development plan. Any effort to do so is done on an ad-hoc basis and only for advocacy purpose.

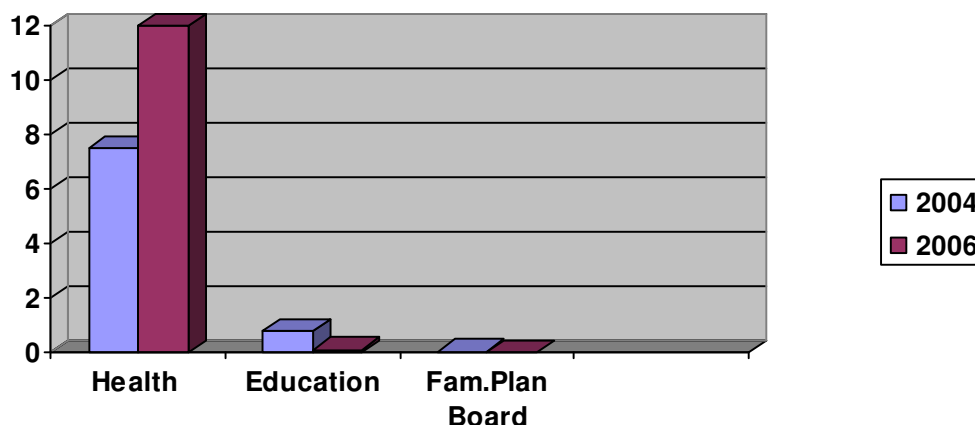


Figure 11: Distribution of AIDS Spending across sectoral ministries (in USD)
 Source: NAC, 2007a and NAC, 2005

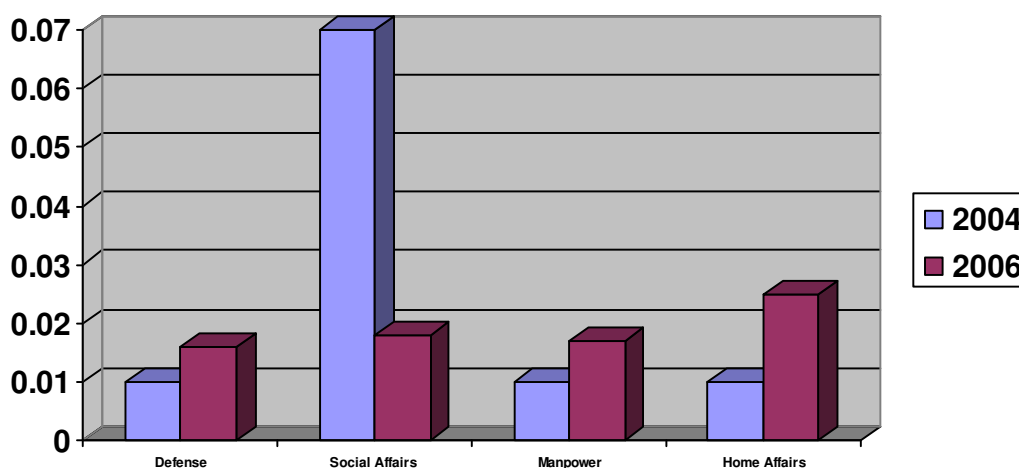


Figure 12: (Cont.) Distribution of AIDS Spending across sectoral ministries (in USD)
 Source: NAC, 2007a and NAC, 2005.

In terms of alignment made by the AIDS donor community, it is important to note that with the absence of a strong NAC secretariat, the development of NAS and other sectoral AIDS plans were very much driven by the donor agencies. In this period, most donors working on AIDS claimed to have aligned their country assistance to NAS (2003-2007) as well as to sectoral AIDS plan. When the Sentani Commitment was launched in early 2004, the donors also claimed that they have aligned themselves to the commitments.

However, based on the project documents, during the implementation period of NAS (2003-2007), USAID grant cycle was from 2002 – 2007 (USAID, 2002) and AusAID grant cycle was also from 2002 – 2007 (GRM, 2002). Each has its own mission for their own project assessments that took place at least a year before. The United Nations have developed a UN Joint Action Programme (2003 -2007) to support the government to implement the NAS 2003-2007 (UNJAP, 2003). It was unclear how the joint plan fit into the United Nations Development Assistance Framework for Indonesia that had a cycle from 2002 – 2005 (UNDAF, 2002). The UN joint action programme did not receive adequate funding for implementation.

Health sector strategy on AIDS 2003 – 2007

In 2001, GFATM has conditioned that as a prerequisite for proposal submission, the country has to provide evidence of the presence of a national strategy and a national operational plan to implement the strategy. Subsequently, the Ministry of Health (MOH) developed an operational plan for the health sector response to AIDS (Reynolds, 2004). The health sector response to AIDS was developed more or less during the same period of time when NAS was being developed. They were broadly aligned to each other (MOH, 2001). Indonesia has been successful for both round 1 and 4 of the GFATM. The Principle Recipient (PR) approved by Country Coordinating Mechanism (CCM) is the MOH-Center for Communicable Disease (CDC). AIDS grant is predominantly used to fund the health sector response. Over half of the grant went to procurement of supplies that included ARV, another bulk amount went to prevention activities and the rest went to technical capacity development of service providers (CCM, 2002 & CCM, 2005)

GFATM grant process supports alignment to country's strategic plan. However, it is up to the CCM to judge to what extent the alignment has been made. This is why capacity becomes an issue for CCM. The approved Round 1 and 4 proposals were clearly much aligned to health sector AIDS strategy as CDC was leading the development of the proposals. CCM had no capacity to review and recommend for more multisectoral approach in the proposals development.

With the reform of CCM governance in 2007, a thematic working group (TWG) is established for each disease (AIDS, TB & Malaria) to support the capacity of CCM to review and develop proposal. TWG membership is an expansion of CCM membership to allow broader participation of technical experts from other sectors. TWG on AIDS is chaired by the NAC, also as a member of CCM. As chair of TWG on AIDS, NAC has managed to ensure alignment of the subsequent proposals to the NAS (2003-2007) as well as to the NAF (2005 -2007).

National Action Framework 2005 -2007

Alignment became more streamlined when NAF 2005-2007 was developed as a prerequisite of DFID grant through the IPF for AIDS. IPF Programme Steering Group chaired by NAC agreed that IPF should be used to maintain and expand the reach that had been achieved by other donors.

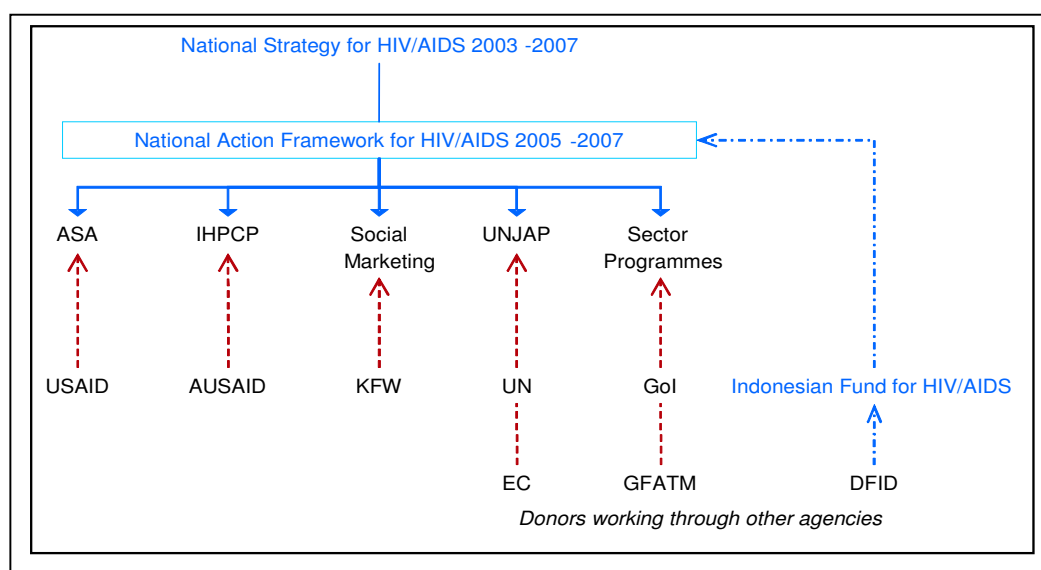


Figure 13: Conceptual framework for NAF 2005 – 2007

Source: National AIDS Commission (NAC), 2007

USAID through its programme -funded Family Health International- Aksi STOP AIDS (FHI-ASA) and AusAID through its programme-funded Indonesian HIV Prevention and Care Project (IHPCP), have played major role in initiating, expanding and maintaining the response across the country. The only barrier to further expansion and acceleration was limitation of resources. Thus, it was seen appropriate for IPF to complement the funding provided by the USAID and AusAID. Subsequently, FHI and IHPCP became sub-recipients of IPF which almost doubled the resources received from their traditional donors, USAID and AusAID. IPF was also used to fund the UN Joint Action Programme 2005 -2007 for WHO, UNDP, UNAIDS, UNICEF, UNFPA and ILO. DKT, the German-funded (KfW) programme, became the next sub recipient of IPF to support further expansion of condom social marketing in Indonesia (NAF, 2005).

IPF was granted to all these international partners with a condition that they should align their programmes, coverage, targets and M&E indicators within the NAF. This process has indirectly lead to the alignment of programmatic response by the two major donors USAID and AusAID, the UN Agencies and the German funded programme (KfW).

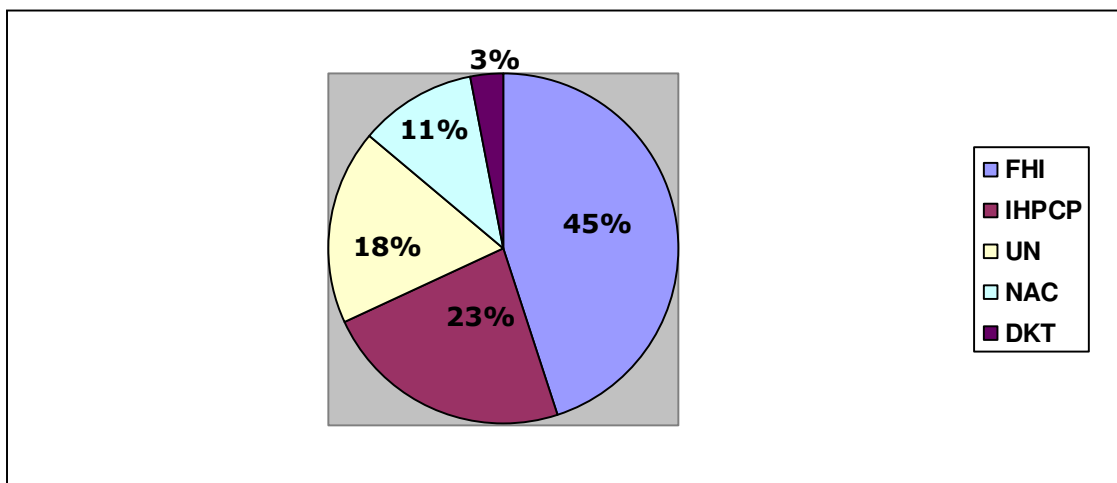


Figure 14: Distribution of IPF 2005 – 2007

Source: National AIDS Commission (NAC), 2007.

Alignment to country’s system

Bilateral donors

None of the two major bilateral donors, USAID and AusAID, directly channels their assistance using the existing country system. Both have traditionally sub-contracted external parties to carry out their programme assistance in Indonesia. Grant from USAID has been sub-contracted to Family Health International (FHI), a US-based NGO. FHI established the Aksi Stop AIDS (ASA) project that focuses on activities to ensure that STI/HIV/AIDS prevention and services remain accessible, available, and of high quality (USAID, 2002). Grant from AusAID has been sub-contracted to GRM International, an Australian company. GRM created the Indonesian HIV Prevention and Care Project (IHPCP) that focuses on harm reduction and strengthening AIDS commissions in multi-sectoral response to AIDS in selected provinces and districts (GRM, 2002). At this level, both programmes work to support the existing HIV and AIDS related services provided by the public (NAC/MOH) and non-profit sector (NGOs).

Multilateral donors.

The United Nations programmes traditionally channel their assistance through their related government counterparts. WHO has always worked with and through the Ministry of Health and UNICEF/UNESCO has mainly worked with Ministry of Education.

In the implementation of the proposal, GFATM grant also encourage the use of administrative and financial mechanism within the system of the Principle Recipient (PR), such as the procurement system, aid management, monitoring, reporting system, etc. In Indonesia, the GFATM grant is channeled through the administrative and financial system of MOH-CDC. But MOH-CDC has to comply with rigid administrative and financial reporting set by the Local Fund Agent (LFA) appointed by GFATM and Price Waterhouse Cooper has been appointed as LFA for Indonesia. This has prompted MOH-CDC to establish a new structure at the national level down to the district level to administer and monitor the implementation of the proposal. It was seen crucial to ensure the ability to deliver targets timely and absorb fund effectively as conditions to further disbursement.

However, it does not answer to an increased capacity by MOH-CDC to manage the grant. Periodical audit and examination from LFA found repeated cases of funding mismanagement. Upon recommendation from LFA, GFATM decided to freeze further disbursement in early 2007 until CCM and the Principle Recipient resolved the issues. GFATM demanded a serious reform within PR agency to improve transparency in the implementation of the proposal. As improvement was made, in late 2007 the disbursement has continued.

Indonesian Partnership Fund (IPF) for AIDS

In terms of grants made through IPF, none of the grants is channeled using the existing country's financial and administrative system because none of the grant is made to any of the sectoral ministries. The grant made to the NAC is made to the NAC's own account. Being independent from the office of the Coordinating Minister for People's Welfare, NAC has created its own admin and financial system with support from UNDP. NAC receives state funding from the Coordinating Minister's office but it does not have an account there.

Grants made to provincial and district AIDS commissions are administered by NAC. However, most of local AIDS commissions are attached to the governor's office at the provincial level or at the office of the district head. None of these commissions were able to receive grants directly from an external source. NAC has no structural budget line to do so unless it goes through the office of the Coordinating Minister for People's Welfare. This implies that IPF grant should be redirected to go to the account of the Coordinating Minister's office. The administrative burden of doing so was

deemed too high. NAC decided that the grants should go directly to the provincial and district AIDS commissions. In condition to receiving IPF grants from NAC, these commissions were asked to establish an account, independent from the local government office.

Challenges in improving alignment

- Challenge remains with leadership to multi-sectoral response. NAS has set the broad strategies for the multisectoral AIDS response but it needs to be translated into a clear operational plan based on a distinct comparative advantage and a clear division of labor among the sectoral ministries. This is a way to ensure one coordinated plan for multisectoral response to provide implementing partners a common framework to align themselves with. But the absence of such plan has given the sector a complete freedom to programme its own response. While the NAC secretariat is mandated to support and coordinate the sectoral response to AIDS, this was not supported with a clear structural line. NAC secretariat has not been able to have any formal influence over how the sectoral ministry is responding to AIDS.
- Additionally, none of the IPF grants is actually going through the existing administrative and financial system of the government of Indonesia, including the grants made to the NAC, PACs and DACs. While there has been a lot of investment going to the AIDS commissions, questions remain about the effectiveness of the approach. Should NAC be strengthened within the existing government system or should NAC be encouraged to become a totally independent body that function more as a fund agent.
- The IPF has been instrumental in ensuring alignment by implementing partners. There is a need to sustain the mechanism to maintain the momentum. Resources need to be mobilized into IPF. However, the prospect of incoming aid has become unpredictable. DFID has announced that it would decrease its contribution to IPF. AusAID also announced that it would contribute to IPF but generally would reduce total contribution to the AIDS response. USAID would not join IPF and generally would reduce total contribution. There is an inclination toward channeling GFATM grant through IPF on the agenda. However, Indonesia has not been successful in securing any GFATM grants for AIDS since Round 4.

4.3 Progress in improving harmonization

In this section, the paper will review (Annex 2):

- To what extent Indonesia has been able to provide AIDS donors with clear complementarity plan to encourage harmonized efforts
- To what extent AIDS donors are willing to develop practices of common arrangements, simplify their procedures at operational level and share public information for coordination purposes

The use of Common Arrangement

Development of country's assistance plan

The AIDS donors have not established a common mechanism for establishing common arrangement. In the first half of the implementation period of NAS 2003 -2007, donors conducted their own missions for project assessments and meet with each stakeholder separately to analyze priorities and gaps.

The United Nations have their own mechanism to coordinate and harmonize the different programmes by its specialized agencies working at country level. The United Nations Development Assistance Framework (UNDAF) 2002 – 2005 and the subsequent 2006 – 2010 for Indonesia reflected a joint approach by the agencies. For the development of UNDAF, the UN agencies together engaged in a Common Country Assessment (CCA).

GFATM Country Coordinating Mechanism

There is one country-established mechanism by way the AIDS donors can meet and have the opportunity to discuss issues on harmonization. This is done through the GFATM CCM where representatives of donor agencies are invited as members. Under its Technical Working Group (TWG) on AIDS, major AIDS projects supported by other donors are also engaged. This process has helped the GFATM proposal to fund the gaps rather than duplicate what others have done. While overlaps of priority programmes are rampant in all donors, duplication is reduced with an agreement to avoid the same geographical areas of work. In another approach, certain donors may choose to focus their supports in certain thematic programmes such as harm reduction (IHPCP) and or condom social marketing (DKT).

IPF Programme Steering Group (PSG)

In the second half of the implementation period of NAS 2003 -2007, there is an additional country-established mechanism by way the donors meet and have the opportunity to discuss issues on harmonization. This is through the IPF Programme Steering Group (PSG), where representatives of donor agencies are also invited as members. The IPF-PSG was established to

provide governance to the implementation of NAF. The adoption of NAF as an operational plan for IPF for implementing partners that also receive grants from other donors such as USAID and AusAID, took place in PSG meetings. The negotiation on how to avoid overlaps through geographical divisions or specialization on thematic areas also took place in an expanded PSG where implementing partners of both donors were invited to participate in the process.

The picture became rather complicated when the UN Agencies participated in the process as IPF implementing partners. Though the UN has already developed an agreement on the division of labours for AIDS, their extent of coverage was far less than the projects implemented by USAID and AusAID.

Joint Analytical Work

During this period, more and more donors are working together in producing joint analytical work. In 2006, the World Bank and USAID jointly supported MOH and the Central Statistic Bureau (BPS) to conduct the first integrated bio-behavioral survey (IBBS) in Tanah Papua. In 2007, WHO is spearheading a joint review on the health sector response to HIV and AIDS. The review team comprised international experts, civil society representatives, people living with HIV, bilateral donors and the Ministry of Health.

The NAC also has established thematic working groups to provide direction for the national AIDS response. Major AIDS donors are often invited as members of the working groups.

Simplifying procedures

Monitoring & Evaluation

There is progress toward simplifying procedures. The NAC and all its implementing partners have agreed to adopt a unified monitoring and evaluation (M&E) system. The NAC has established an M&E working group for the development of a national M&E guidelines. The guidelines have been used to monitor progress of accelerated response in 100 priority districts as defined by NAC (NAC, 2007a).

Reporting

There is limited progress in making the administrative burden simplified for reporting and monitoring purposes. An NGO receiving grant from GFATM, USAID/FHI-ASA, AusAID/GRM-IHPCP still has to provide individual report to each of the donor.

Sharing information

There is no established mechanism by way donors can share information to each other. However, sharing information is a norm. Individual analytical work done by each donor is usually shared with other donors. With more and more donors come together for a joint approach, a more established mechanism is perhaps underway. IPF final report shows an effort to collate the progress results from implementing partners that also takes into account the contribution made by other donors such as GFATM, KfW, AusAID and USAID.

Challenges in improving harmonization

- There is no established mechanism for common arrangement in the Indonesian AIDS response. It is still largely depending on the willingness of each donor agency to engage other donor in its work. There is more inclination that the government leads this process.
- The IPF Programme Steering Group (PSG) has tried to facilitate discussion toward harmonization, not only at policy level but also at operational level. However, the challenges was for NAC to assess to what extent the proposal negotiated by each implementing partner is actually reflecting its best comparative advantage. But the ultimate challenge was to ensure that all proposals combined were the most strategic combination to achieve the target of NAF. NAC needs to increase its capacity not only to review proposals but also to develop a common complementarity plan.
- Challenges in harmonization are at the operational level or service provision level where implementing partners funded by different donors are working. Different projects have their own procedures. For example on human resources policy and scheme, the different projects have not yet adopted common policy in terms of salary scales and or incentives. Also at the operational level when people are often under pressure to reach their designated targets, there are no incentives toward ensuring harmonized programme approach. Conflicts often arise about geographical overlaps and overlaps of target population. FHI and IHPCP complained that in many instances GFATM grants had been utilized in duplications with already existing programmes.

4.4. Progress in improving management for results

In this section, the paper will review (Annex 2):

- To what extent Indonesia is able to develop a common monitoring and evaluation framework to generate strategic information for improved decision making and programme planning and to produce results-oriented framework that monitor progress against a clear set of indicators and targets
- To what extent AIDS donors are supporting Indonesia to develop results-oriented reporting and framework that can be linked to their country programming and resources and a common monitoring and evaluation framework to generate strategic information for improved decision making and programme planning

MDG & UNGASS

Indonesia has signed a commitment to work toward achieving targets set by MDG and UNGASS Declaration of Commitments. The country has regularly reported progress made against a set of indicators set in both commitments.

As a follow-up to the development of the NAS (2003-2007), the NAF (NAF) 2005-2007 was developed with support from UNDP and UNAIDS. NAF was made to cost and operationalize NAS with clear targets and indicators. Implementing partners' reports are geared toward reporting progress in achieving these targets.

GFATM

GFATM grant is also performance based. All proposals submitted to GFATM should set a clear target and a set of indicators to measure progress toward the targets. Disbursement would be made on the basis of results and progress.

Universal Access

As per the commitments made in the Political Declaration on HIV and AIDS adopted in June 2006, Indonesia has developed the NAS 2007-2010 that also has been followed by the development of a National Costed Action Plan (NCAP) 2007-2010 (NAC, 2007c).

Challenge in improving management for results:

Challenge in improving management for results is to assess to what extent the development of these plan, its targets and indicators and the desired impact, has been evidence-informed. Is there adequate investment made toward making analytical work to base the development of the plan.

4.5. Progress in improving mutual accountability

In this section, the paper will review (Annex 2):

- To what extent Indonesia has developed framework for mutual accountability on making aid more effective
- To what extent the AIDS donors are supporting Indonesia in developing framework for mutual accountability on making aid more effective?

Mutual Accountability for aid effectiveness is somewhat left out from the discussion. The government has no mechanism or framework to assess how efforts have been delivered to improve aid delivery. The discussion on aid effectiveness stops when everybody is already pleased with the increased ownership, better alignment and enhanced harmonization process. The discussion on whether these have brought about result towards the desired impact, e.g. health outcome, has not happened.

Chapter 5: Case Study

Review of Aid Effectiveness in Papua AIDS Response

5.1. Papua profile

The current Papua province consists of 19 districts and 1 municipality. Jayapura is the capital city of the province. Total population of Papua in 2007 is around 2 million people (BPS Papua, 2007). Though the province is comparatively richer than any other provinces in Indonesia in terms of natural resources, it is actually one of the poorest provinces in Indonesia. It is estimated that over 70% of the population lives in rural area and almost half of the total population lives under US \$1 per day. Most children in Papua attended primary school but less than 20% actually continue and graduate from senior high school. Infant mortality rate is at 50.5 per 1000 live birth and maternal mortality rate is 1.116 per 100,000 births (UNDP, 2005).

Major causes for mortality and morbidity in Papua are mostly related to communicable and sanitation-related diseases. AIDS, TB and Malaria are no exception. Papua tops the list of the highest national epidemics for all three. A recent development assessment made by UNDP cites that on the health sector front (UNDP, 2005), coverage of public health services is very limited due to infrastructural and geographical constraints. Remote population heavily relies on the services of the nearest community health centers that are mostly located in the capital of the sub-districts or mobile community health centers that provide mobile health services across the district levels. Papua also has a severe shortage of health personnel. Most of the health force is working in the urban setting.

Papua is currently implementing its medium term development plan (RPJM) 2006 -2011. The provincial development planning board (BAPPEDA) is in the process of finalizing the plan for the longer-term development (RPJP) 2008 – 2028 (BAPPEDA, 2008). Since the special autonomy status was given to Papua province, most international development partners working in Indonesia have increased their scale and level of support to the development of Papua. The number of partners and the projects they support are enormous. To coordinate their activities, the government of Papua has also established a local coordination forum for development partners, led by BAPPEDA. Recently there has been a joint donors' effort to develop a common development framework for Papua, led by UNDP (UN, 2006).

5.2. AIDS Epidemic in Papua

In 2006, Indonesia conducted the first integrated bio-behavioral survey for Papua and West Papua. The first AIDS case detected in Papua was in 1992. Since then, the epidemic has spread rapidly that by 2006, HIV prevalence in Papua and West Papua combined is already at 2.4%. The major mode of transmission is through unprotected heterosexual contact. Alcohol abuse is a major problem in adolescence group (BPS, 2007).

The result of the survey also revealed that prevalence among the male population is much higher (2.9 percent) than among the female population (1.9 percent). Prevalence is highest in the 40–49 age groups, at 3.4 percent, followed by 15–24 year-olds at 3.0 percent. HIV prevalence is also higher in areas where access is difficult. The same areas also reported a low level of knowledge about AIDS and low condom use. Overall knowledge about AIDS among the general population in Papua is also very low: 48 percent had never heard of AIDS.

An AusAID's epidemiological modeling and impact study estimated that around 13,000 people are living with HIV in Papua in 2005. The epidemiological modeling suggests that the number will increase to 29,000 by 2010. The quarterly HIV and AIDS report released by the Provincial Health Office are far under reporting this estimation. By end of June 2008, MOH reported 110 new AIDS cases and 1492 cumulative AIDS cases (AusAID, 2006).

5.3. AIDS Response in Papua

Prevention

Focus on prevention is on Information, Education and Communication for behaviour change targeting the general population and youth in particular. Condom promotion is a major component of the prevention activities in Papua. AusAID supported UNICEF in piloting school-based life skills education in Papua that include HIV prevention messages. Since the health system strengthening project started, it has reached a total of 55 community health centers (Puskesmas), 17 hospitals and 5 clinics with integrated support and training for IMAI, VCT, Case Management and laboratory support. Two puskesmas also conduct prevention outreach to youth and street children in Jayapura city (NAC, 2008).

Care, Support and Treatment

Following the epidemiological modeling for Papua, it is estimated that around 20% of those living with HIV is in need of treatment or around 2,600 people (AusAID, 2006). The provincial health office reports only around 400-500 people are on treatment in Papua (POH). An integrated VCT and PMTCT services have been established in 6 Puskesmas in Jayapura district and city. It has managed to improve outreach to pregnant women by bringing the service closer to the community (NAC, 2008).

Impact Mitigation

In Papua, little has been done in this area of impact mitigation. UNICEF has started a campaign to protect children from HIV and AIDS. It includes social protection programme for children orphaned by AIDS. ILO and UNDP has jointly organized Start Your Business project, aimed at providing

entrepreneurial skills for people living with HIV. Both programmes include Papua as one of the target provinces. (UN, 2003)

Commitment and Policy

The provincial AIDS Commission in Papua was established by the Presidential Decree in 1994 that stipulates the establishment of the NAC and AIDS commissions at the provincial/districts levels (Keppres, 1994).

After the development of the NAS 2003-2007, Papua has developed its provincial Strategic Plan for 2005-2009 with support from its international development partners. The principle focus of the plan is on preventions interventions for sexual transmissions of HIV and care, support and treatment for people living with HIV (PLHIV) (PAC, 2005). This was largely triggered by the signing of the Sentani Commitments in early 2004. Papua is one of the provinces participating in the commitment. In 2006, Indonesian President Susilo Bambang Yudhoyono also visited Papua and had the first hand experience on how serious the AIDS epidemic had spread across the province. He urged the government of Papua to accelerate response to AIDS. As a result, Papua provincial budget has increased from around IDR Rp3billions in 2004 to more than IDR Rp6billions in 2006 (Karma, 2006).

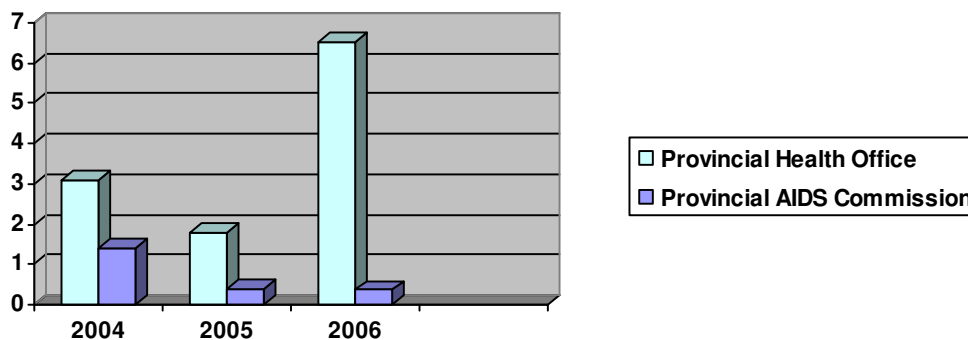


Figure 15: Provincial Budget for AIDS in Papua According to source in IDR (billion)

Source: Karma C, 2006.

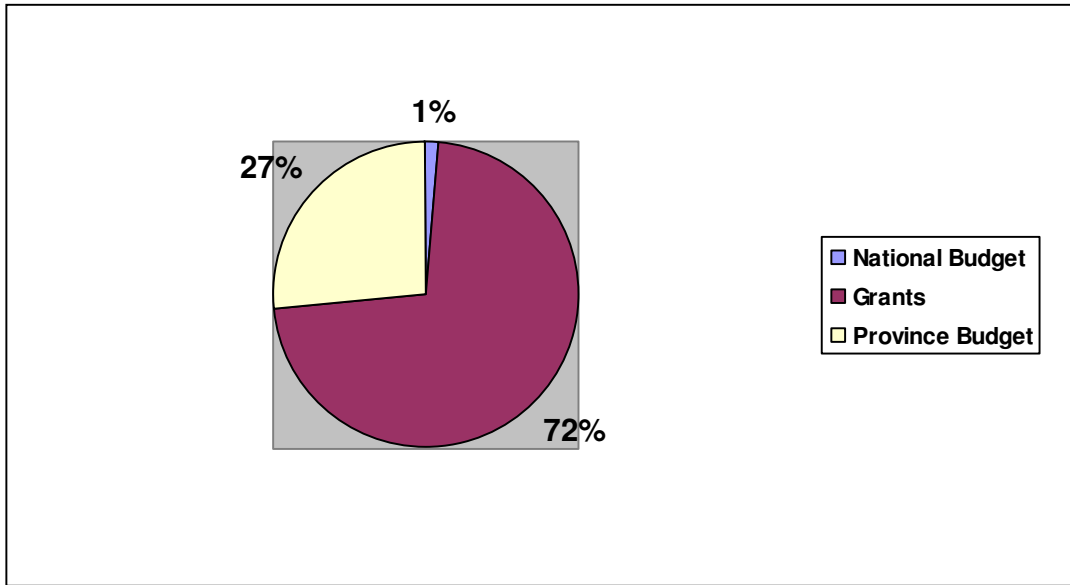


Figure 16: Provincial Budget for AIDS in Papua According to source in USD (million)

Source: Mboi N, 2007

During the implementation of NAS 2003-2007, there are five major donors supporting AIDS response in Papua; USAID through FHI, AusAID IHPCP, DFID through grant made by the IPF on AIDS to NAC, UN through its specialized agencies and GFATM through the Ministry of Health (MOH). All combined represent over 70% of total AIDS spending for Papua.

Based in its project document for Papua, AusAID through IHPCP has focused its support in developing the capacity of the AIDS commission at the province and district level. IHPCP has seconded several staff to the commission and has supported the development of the provincial AIDS strategy (GRM, 2002). USAID through FHI-ASA has focused its support in strengthening the delivery of services at the community level for HIV prevention, care and support (USAID, 2002). GFATM through the provincial health office also focused its support in the delivery of services at community level but largely for care and treatment purpose (CCM, 2005).

In Papua, the NAC has prioritized for an accelerated AIDS response in 18 districts. With IPF grant, staff is recruited to support the provincial AIDS Commission and AIDS commissions in 18 districts in Papua (NAC, 2007c).

A health system strengthening plan is developed by the provincial health office with support from FHI and WHO. It started in 2006 with a focus on strengthening six components of the health system; service delivery; human resource capacity; financial resources and management; management; community mobilization and outreach; and the logistic of health service delivery. This is on the premise that by strengthening the health system, it would also strengthen the health sector response to AIDS (NAC, 2008).

5.4. Towards Improving Aid Delivery for AIDS in Papua

In this section, the paper will review aid effectiveness in the AIDS response for Papua province, using the same framework of analysis developed for the review at the national level and following the questions generated in Annex 2 to guide the flow of analysis.

5.4.1. Progress in Improving Ownership

Ownership

Provincial AIDS Commission

The Government of Papua has designated the Provincial AIDS Commission (PAC) to lead, coordinate and manage the multisectoral AIDS response in Papua. PAC is officially chaired by the Vice Governor to ensure high-level of leadership at the province level. Members of PAC mostly comprise of senior civil servants working in sectoral ministries and government agencies at the provincial level.

During the first half of the implementation period of NAS (2003-2007), PAC has no clear structure for partners to liaise with, without staffing and an operational plan to do its duties. After the signing of the Sentani Commitment in early 2004 and the president's call to accelerate AIDS response in Papua, there was sign of increased ownership reflected on the increased budget allocated for the AIDS response. However, it was primarily from the health sector.

Most progress in improving ownership occurred with the development of the NAF (NAF) 2005 – 2007 and the establishment of the IPF (IPF) to finance NAF. With IPF grant made through NAC, PAC has been able to recruit full time staff to administer its duties. AIDS Commissions are also established in 18 districts with full time staff (DACs).

Provincial spending on AIDS

The major sources of funding for the AIDS response in Papua still comes from external aid. GFATM grant is the biggest multilateral contributor while USAID and AusAID combined makes the biggest bilateral contributors. This influences who sets the agenda for programme priorities and scale of the response. Indeed with donor supports, PAC managed to develop an AIDS strategic plan for 2005-2009. Unfortunately, it makes a weak link to the provincial medium term development plan (RPJM) 2006 -2011 that defines the provincial development priorities and allocate resources based on the priorities. The provincial budget allocation for AIDS mostly goes to the health sector with a small proportion goes to the provincial AIDS Commission to support its operation. Other sectors have not yet adopted the AIDS strategic plan into their medium term work-plan to be included in their sectoral RPJM.

Challenges in improving ownership

- Local leadership and commitment are in question. While the government of Papua has shown its commitment with the development a provincial AIDS plan and an increase in AIDS spending, this is still largely due to the prerequisite of donors funding. With the completion of NAF and the closure of DFID support to IPF, there is a transition to move PAC/DACs operation budget from IPF grant to provincial / district budget but this has not been completely resolved. Particularly at the district / municipality level, this largely depends how the local administration authority see the importance of having a fully operational DACs.
- There is an unclear link between the NAC, PAC and DACs. With the acceleration programme in 100 priority districts and cities directly led at the national level, the relations between the provincial commissions and the district AIDS commission has been strained. All DACs are reporting directly to the NACs. PAC has been bypassed by this approach.
- There is a need to sustain and expand capacity at the provincial and district AIDS commissions to exert its mandates. IHPCP, FHI and the UN agencies working in Papua have provided technical assistance for capacity development. But this depends on what programme priorities they have in their overall strategy support for AIDS response in Papua. IHPCP seconded a public information officer for the provincial AIDS commission. FHI support for capacity development is mostly targeting technical capacity development for service providers both from the government sector and NGOs. GFATM capacity development is mostly targeting health sector. There is no coordinated plan for a comprehensive capacity development at the province level.

5.4.2. Progress in improving alignment

Alignment to provincial policy & plan

Provincial AIDS Strategy 2005 -2009

In ensuring alignment, the province has developed an AIDS strategic plan for 2005-2009. However, it was not followed by a clear and costed multi-sectoral operational plan for all stakeholders to base their work. Most local and international implementing partners can claim that they have broad alignment to the strategy but they still have to conduct their own assessments to decide on their programme priorities and the scale of interventions.

Aside from the UN agencies, the donors do not have official presence in the provincial level. Most analytical works are done in individual missions during the preparation for the project assessment. Though developed with consultation at the provincial level, the design of programme support is mostly done at the national level.

GFATM has included Papua as one of the priority provinces for AIDS response. But the proposals have been developed at the national level with little engagement from local stakeholders. The UN has started a joint response to AIDS in Indonesia but the UN response in Papua has been very fragmented depending on which UN agency has a presence in the province. UNICEF has a strong presence in Papua, thus the response has been mainly supporting the protection of children from HIV infection and AIDS impact through support to the education sector and the social welfare sector. Jointly with WHO, UNICEF has also provided support for PMTCT programme in Papua (UN, 2003).

National Action Framework 2003 – 2007

Alignment in Papua was more streamlined when implementing partners like FHI and IHPCP that receive grant from major donors such as USAID and AusAID, also receive additional grant from the IPF. The UN agencies were also part of this alignment process as some of the agencies that work in Papua also receive grant through IPF. However, the discussion about alignment in Papua mostly took place at the national level. The alignment was made to the NAF 2005-2003 and not specifically to any provincial strategy or policy.

Provincial Health System Strengthening plan for AIDS 2006

The development of Health System strengthening plan by the provincial health office of Papua in 2006 signals a more localized approach to the epidemic, though it is still very much health services oriented. It focuses on strengthening six components of the health system; service delivery; human resource capacity; financial resources and management; management;

community mobilization and outreach; and the logistic of health service delivery. This is on the premise that by strengthening the health system, it would also strengthen the health sector response to AIDS (NAC, 2008). A pilot implementation took place in Jayapura city and was deemed successful (NAC). The plan has not received adequate funding to accelerate the implementation across the province. The provincial health office is trying to mobilize resources from donor agencies for this purpose.

Use of local government's system

Bilateral donors

None of the two major donors, USAID and AusAID, directly channels their assistance using the existing country system. Both have traditionally sub-contracted external parties to carry out their programme assistance in Indonesia. Grant from USAID is going through FHI and grant from AusAID is going through IHPCP. Both organizations largely work with non-government organizations in Papua. Supports for the government are usually made in the form of technical assistance such as staff secondment or on the job training.

Multilateral donors

The grant from GFATM is the only grant channeled using the government's financial and administrative system. In Papua, GFATM grant is channeled through the provincial health office.

The UN agencies traditionally channel their assistance through their related government counterparts. In Papua, WHO works with the provincial and district health office while UNICEF works with the provincial and district education office. UNDP works with the provincial planning and development board (BAPPEDA).

Indonesian Partnership Fund (IPF) for AIDS

As discussed earlier, IPF grants made to PAC and DACs in Papua, came through the NAC. In condition to receiving IPF grants from NAC, these commissions were asked to establish an account, independent from the local government office.

Challenges in improving alignment

- A solid local AIDS plan is lacking. IPF has been instrumental in ensuring alignment by implementing partners. But this is largely done at the national level with little involvement from local stakeholders. Alignment at the local level is difficult when there is no local plan that binds partners to local targets. The development of the health system strengthening plan is a signal to move toward such direction. The challenge is for the local government to develop a donor complementarity plan as a framework for

a joint approach to the plan rather than dealing with parallel approaches by individual donor.

- Grants made to the provincial and district AIDS commissions were made outside the existing local government admin and financial system. Questions remain about the effectiveness of this approach, should the AIDS Commission be strengthened within the existing government system or should they be encouraged to become auxiliaries of NAC as a totally independent body that function more as a fund agent.

5.4.3. Progress in improving Harmonization

Common Arrangement

Development partners' forum

There is no established mechanism for common arrangement. The government of Papua has established a local development forum for development partners in Papua. This only includes major UN agencies and international implementing partners that have presence in Papua. AIDS is regularly included on the discussion agenda. All major implementing partners working for AIDS response in Papua are invited to participate in this forum.

GFATM-CCM & IPF PSG

There has been discussion among AIDS donors about harmonization on AIDS response in Papua. However, they mainly took place at the national level through the discussion in GFATM-CCM forum of IPF-PSG. The provincial and district AIDS commissions occasionally organized coordination forum where all stakeholders are invited. But they are mostly on an ad-hoc basis, related to planning purpose and or events.

Simplifying procedures

Monitoring & Evaluation

NAC has developed a unified M&E system to monitor progress of accelerated response in 100 priority districts as defined by NAC.

Reporting

Similarly discussed at the national level, local implementing agencies funded by many different donors still have to provide individual reporting to each donor.

Sharing information

The coordination forum for development partners in Papua led by the provincial planning and development board (BAPPEDA) has started regular mapping of donor supported projects in the province. The result is released publicly for all development partners. Most of AIDS related projects are reflected in the mapping document.

Challenges in improving harmonization

- While there has been local mechanism developed for coordination of development partners in Papua, there is no room to accommodate for a systematic harmonization process that is needed for the AIDS response in Papua. It is only a general forum. Coordination forum for AIDS donors is only possible through the provincial AIDS commission. But this is done on an ad-hoc basis, depending on the need seen by PAC, and mostly related to planning purpose and or events.
- The IPF PSG has helped facilitate discussion toward harmonization, not only at policy level but also at operational level. However, the discussion took place at the national level and not at the local level.
- Local implementing agencies funded by many different donors still have to provide individual reporting to each donor. There is no incentive toward ensuring harmonized programme approach at the operational level. People are working to achieve their own targets. Conflicts often arise about geographical overlaps and overlaps of target population. This is particularly between FHI-IHPCP and the GFATM funded partners.

5.4.4. Progress in improving management for Results

National Action Framework 2005 – 2007

As defined by NAC, Papua is one of the top priority provinces for the acceleration of AIDS response. NAF 2005-2007 had outlined clear targets and indicators for Papua. Implementing partners' reports are geared toward reporting progress in achieving these targets. Papua also received GFATM grants. Disbursement would be made on the basis of results and progress delivered at the operational level.

Challenges in improving management for results:

Though Papua has developed its provincial AIDS strategy 2005 – 2009 and a health system strengthening plan for AIDS, the challenge in improving management for results is to assess to what extent the development of these plan, its targets and indicators and the desired impact, has been evidence-informed. Is there adequate investment made toward making analytical work to base the development of the plan.

5.4.5 Progress for Mutual Accountability

At the national level, not much has been done in terms of establishing a mechanism for the country and its donors to discuss mutual accountability. As Papua has developed a forum for development partners, the discussion about how to hold each other accountable for improving aid delivery in Papua should start from here. This is an opportunity for the provincial AIDS commission in Papua to start doing so.

Chapter 6: Conclusion, Discussion & Recommendation

Based on this study, the road toward Aid Effectiveness in the Indonesian AIDS response has been paved. There is a transition to progress upward the pyramid of aid effectiveness where the recipient-country eventually takes the lead. Once the national leadership and capacity have been strengthened, donor countries have started to align and harmonize themselves. However, there still challenges along the way that needs to be addressed.

6.1. Improving Ownership

Based on the study, the main challenges in improving ownership in the Indonesian AIDS response are:

- **Sustaining and expanding leadership and capacity of NAC**

In the report on the progress of the Three Ones, UNAIDS clearly stated that: *"the absence of string mandates and support as well as absence of human resource capacity / management and institutional authority are barriers to making one agreed national aids authority"* (UNAIDS, 2005a). With the new Presidential Regulation in 2006, progress toward making one agreed national AIDS authority was made. It has stipulated the appointment of a full-time secretary and the establishment an independent secretariat to the NAC. It also has reinforced the authority to lead, coordinate and manage the national response; and the accountability to the President. Provincial and district AIDS commissions are being established in 100 cities/district across 22 provinces in Indonesia. The NAC, PACs and DACs have been made able to deliver on their responsibilities.

However, the national commitment is still in question. The national AIDS response is still largely dependent on its donors. Many of the progress made is merely responding to the prerequisite of donor funding. With the completion of NAS 2003 -2007 and the decrease in overall donor funding for the AIDS response in Indonesia, it is feared that national leadership and commitment would also drop. The same applies to the context of Papua province where over 70% of its AIDS spending relies on external aid.

Learning from Thailand success story in public financing for AIDS, the country has managed to reverse the ratio of 90% external funding to 5% in 1996 by spearheading multisectoral allocations of funding for AIDS (ADB, 2004). This was possible due to a high political commitment from the Thai government to control its AIDS epidemic that was translated not only into policy paper but also into an increase of state budget allocation for AIDS. The Indonesian government needs to seriously learn from this experience to explore innovative ways to finance the AIDS response using domestic resources.

- **Defining the most ideal model for the NAC to provide a more effective management of the AIDS response in Indonesia**

In the report of AIDS Commissions in Asia, it has been highlighted that many Asian countries have established one national authority for AIDS response following the Three Ones principles. However, the report also pointed the diverse variation of political status, authority, capacity and responses. Effective coordination is lacking due to unclear mandates, absence of secretariat support and overall political direction (CAA, 2008).

Globally, there is an emerging discussion about transitioning the role of NAC as a multisectoral coordinating body into a national AIDS funding agency (Dickinson, 2006). It is suggested that the most critical issue at the national AIDS response is how to allocate the fund effectively, how to decide where the funds go and how to monitor the results.

The current model of NAC that comprises ministerial board members and a secretariat does not seem like an answer to that need. This model is heavily bureaucratic in nature and it often hampers the speed needed to respond to AIDS effectively. The current model is also fragile to political instability which can threaten sustainability of leadership, capacity and resources. Experience in South African AIDS response showed how political views over how one gets AIDS and how one gets treated have negatively impacted the AIDS epidemic in South Africa. This is despite the existence of a national authority and health infrastructure that can actually deliver response required (Parkhurts, 2004).

In Indonesia, DFID support for IPF that ran through 2005-2007 has allowed NAC to implement NAF 2003-2007 forcefully. By experience in managing the IPF, the NAC can actually exert more authority in leading, coordinating and managing the response. However, with the completion of NAF and the total reduction of AIDS funding from external sources, question remain on whether NAC would be able to continue exerting its authority.

Indeed, the Perpres 2006 has regulated that NAC is mandated to function as the national authority for AIDS response in Indonesia. But the Perpres still leaves many institutional arrangements unanswered. The mandates for leading, coordinating and managing the AIDS response are on paper but without clear translation into accountability lines to all the stakeholders. NAC has the mandates but has no binding mechanism.

This implies the need for NAC to review its current model and explore others, to define the most ideal model that can provide a more effective management of the AIDS response.

- **Defining the need for comprehensive capacity development and mobilizing coordinated support from donors**

Uncoordinated and fragmented support for capacity development has been cited as one of the major challenges in improving ownership in the Indonesian AIDS response. The progress report of Rome Declaration cited that the recipient-country needs to be able to lead the aid coordination process forcefully to ensure a fully coordinated response from the donor-countries. *"This involves process, skills, management capacity, mature political judgment and sometimes political courage"* (OECD, 2005). NAC needs to assess all these factors and see up to what extent it can do so at present and in the long run.

During the implementation period of NAS 2003 -2007, support for capacity development is focusing more on strengthening capacity at the operational level or service providers while capacity for the management of AIDS response is often overlooked. According to a recent UN survey of Aid Effectiveness, *"capacity gaps mostly remain in analytical, policy, strategic and evaluation capacity"* (UN ECOSOC, 2008).

This is confirmed by the latest review of the health sector response in Indonesia. It suggested that *"limited capacity in HIV programming of the provincial and district programme managers and implementers, as well as a lack of coordination within the structure of the new AIDS commission, have adversely affected the current response"* (WHO, 2007). This implies a need for NAC to assess current capacity gaps in the Indonesian AIDS response and follow it up with a grand plan for a comprehensive capacity development with clear targets, a set of indicators and the desired impacts.

In Papua, the development of the health system strengthening plan for AIDS has signaled progress toward such direction. The plan has included the strengthening of all six components of the health system, including the human resources capacity.

- **Defining linkages to the provincial and district AIDS commission**

A recent global review on NAC governance highlighted the structural challenge of NAC, PACs and DACs. Alignment within these actors largely depends on whether there exists any formal and structural linkage among them (Dickinson, 2005). NAC is an independent national commission established by a presidential regulation and chaired by the Coordinating Minister for People's Welfare. It receives state funding through the Coordinating Ministry's office but it is not a formal auxiliary of the ministry. PACs and DACs are also independent commission at the local levels, usually chaired by the Vice Governors or the heads of districts. PACs and DACs receive state funding through the office where they are hosted. It is clear that without direct link of budget line, there is no direct line of accountability among the NAC, PACs and DACs.

In the case of Papua, with IPF grants made to PAC and DACs, the NAC has been made able to exert its authority over the utilization of fund; where the fund is going, what the fund is for and how fund performance is measured. Without IPF grants, this approach is not sustainable. Subsequently, NAC can only advocate for the roles and responsibilities of PAC and DACs and hope that the local governments would utilize and finance their PACs and DACs. Since the decentralization policy took effect in 2001, the local governments have the utmost authority in deciding their own development priorities and in mobilizing resources to finance them. In this respect, NAC needs to review its current model of linkage to PACs and DACs and explore others, to define the most ideal way of decentralizing AIDS response.

6.2 Improving Alignment

Based on the study, the main challenges in improving alignment in the Indonesian AIDS response are:

- **Sustaining a solid and costed AIDS action plan and a clear linkage to sectoral partners at local, national and international level**

In the report on the progress of the Three Ones, UNAIDS clearly stated that the *absence of multisectoral agreement and absence of a carry through to work plans and budget are barriers to achieving one agreed national framework (UNAIDS, 2005a)*. When NAS 2003 -2007 was launched, it was not immediately followed by a costed operational plan. This occurred only in the second half of the implementation period when DFID funding came through the IPF (IPF) for AIDS. With support from DFID and other donors, NAC developed its first operational plan, the NAF 2003-2007. NAF was able to provide a common framework for all partners to base their work on, especially for those receiving grants from IPF.

However, this has little effect on the alignment of sectoral plans to NAF. None of the sectoral ministries receive funding from IPF. NAC also has no direct accountability lines to the sectoral ministries to be able to exert its influence over their AIDS plans. NAC has to advocate for alignment because this is the only way NAC can ensure linkage of its national AIDS plan to the medium-term expenditure plan and the national medium-term development plan. The effort to do so has been delivered on an ad-hoc basis.

In leading a multi-sectoral response, NAC also needs to have the skills and the capacity to mainstream AIDS in the development agenda. NAC needs to assess whether it has the right level of skills and capacity to do so (Dickinson, 2006). UNDP recommends that in low-level or concentrated epidemics, NAC needs to define what are the priorities and which sector is the most relevant to deliver the priorities (UNDP, 2008). It is not possible or necessary to involve all sectors in the AIDS response in this context as resources are constrained.

The goals of multisectoral response need to be clarified. Should it be about ensuring participation of all branches of the government in the AIDS response or about encouraging expanded involvement from non-state actors. Which approach would be more effective in the context of the Indonesian AIDS epidemic (Putzel, 2004). When goals are clear, then NAC needs to review structural linkages to multisectoral partners to explore the most ideal model of working together.

- **Defining and strengthening the national management system for AIDS response and mobilize coordinated support from donors**

Aside from the grant made by GFATM that is channeled through MOH-CDC, none of the grants made by other donors to the Indonesian AIDS response are channeled through the existing country system. Even the IPF grants that are made to the NAC, PACs and DACs, have required these commissions to establish their own accounts, external from the government offices hosting them. The progress report on Paris Commitment stated that *"the degrees to which donors rely on the existing country system varies considerable, depending at least partly on the quality of the system and on such other factors as the existence of reform programmes"* (OECD, 2006).

In convincing donors to start using country system, recipient country needs to start showing progress in strengthening its management system, especially in terms of administrative and financial capacity. In the context of the Indonesia AIDS response, the question arise; whose and which system to strengthen? The mandate of leading the national AIDS response is designated to NAC. But NAC needs to define its identity whether it is part of the government system as an auxiliary of the Coordinating Ministry's Office, or it is an independent body established by the government to lead the national response. Only when it has been clarified, efforts to strengthen the national management system for AIDS response can be mobilized and coordinated.

There is a need to clarify and define the national management system for AIDS response before developing and mobilizing support for a grand plan for capacity development

- **Defining longer term plan for AIDS response and ensuring commitment for predictability of aid for sustainable AIDS response**

UNAIDS Global AIDS Report 2008 highlighted that almost half of all funding recipient-countries reported partial progress in achieving full alignment and harmonization. Not all external partners have fully aligned their assistance with the national HIV strategies (UNAIDS, 2008).

In Indonesia, the role of IPF in financing the implementation of NAF 2003-2007 has been instrumental in ensuring commitment and alignment by implementing partners. NAC is spearheading efforts to mobilize more

resources into IPF to sustain the momentum. However, major donors have announced an overall reduction of total contribution to the Indonesian AIDS response. NAC faces a huge challenge to find resources to maintain existing response. Surrendering the national AIDS response to the cycle of donor funding has resulted in less predictability of sustainable financing of the response.

WHO has insisted in its report on Aid Effectiveness in Health that predictability of aid should be improved for resources to be used well. This entails donor-countries adhering themselves to alignment of country's development plan and multi-year budget commitment as agreed in Paris Declaration (WHO, 2007). NAC has developed the subsequent NAS 2007 – 2011 that has been translated into a costed operational plan. Projection of budget need for the implementation of NAS 2007 – 2011 has been provided. The major challenge is still to gain interest and multi-year budget commitment from major AIDS donors. It is also critical to ensure that resources mobilized are untied and flexible. Flexibility will provide room for adapting the national response to the country's changing epidemiological characteristics (Oomman, 2007). However, a recent report on the perception on aid effectiveness by development partners in Indonesia highlighted that it would largely depend on the donor countries political interest, programme priorities, legal constraints and perceived incentives (Walsh, 2005). High level bilateral and multilateral dialogue needs to take place to negotiate for this to happen.

There is a need to ensure that AIDS is included in the government's development agenda during its bilateral and multilateral discussion on development aid for Indonesia. NAC needs to get familiar with the Indonesian foreign policy setting to be able to exert its agenda.

6.3. Improving Harmonization

Based on the study, the main challenges in improving harmonization in the Indonesian AIDS response are:

- **Defining comparative advantage, clarifying division of labors and developing a complementarity plan**

The progress report on Paris Declaration encouraged the development of local harmonization plans at country level that includes a complementarity plan based on comparative advantages of each partners (OECD, 2006). The GTT report also highlighted the critical need for a clear division of labours among all international partners to ensure that resources could be used rapidly (UNAIDS, 2005b).

In this respect, the NAF 2003-2007 was able to provide a common framework for all partners to base their work on, especially for those receiving grants from IPF. However NAF does not really come with a clear outlines for the division of labors among all its stakeholders. NAC had to

spend enormous time negotiating proposals with each implementing partner to see where they each fit into NAF. While eventually a collaborative programming was made, NAC needs to divert this process with a preliminary assessment of partners' comparative advantage.

Recommendation: A clear division of labor and a complementarity plan needs to be developed in a consultative manner with all major donors and implementing partners.

- **Defining the need for a common arrangement**

The progress report on Paris Declaration cited that effectiveness of aid delivery would be significantly enhanced when the recipient country establish a mechanism for coordination that sets a common framework with shared objectives to constructively reconcile different interests by all stakeholders (OECD, 2006). The report also recommended the use of programme based approach for a more effective model to coordinate development assistance.

NAF 2005-2007 has partially represented a move toward programme based approach to the AIDS response in Indonesia. It has based its implementation on the leadership by the host country and it has provided a common framework. To some extent, it has pushed forward donor coordination and harmonization. There is also progress in creating common arrangement for donors. In 2006, several donors agreed to conduct joint analytical work in Papua and supported an integrated bio-behavioural survey (IBBS) in the province. However, this is not an established mechanism and is largely dependent to the willingness of each donor agency to engage other donors in its work. There is more inclination that the government leads this process.

- **Defining the need for simplified procedure at operational level**

GTT report noted that despite commitments from donors to simplify their procedures and requirements at country levels, recipient countries still face many requests to develop individual reports for each donor that differs in cycles and format (UNAIDS, 2005b). Similarly in the Indonesian AIDS response, harmonization is done superficially in terms of harmonizing programmes to reduce overlaps, but very limited progress has been made to simplify administrative burden for reporting and monitoring purposes at operational level. Additionally, no incentives offered toward ensuring harmonized programme approach at the operational level. People work for their own targets. There is a need to have a formalized mechanism to start simplifying procedures by different donors at the operational level that have often taken people away from the core of their programmatic work. Implementing partners also need to be encouraged to work in collaboration with one another. It needs to be in the term of reference and a positive incentive needs to be given toward such behavior.

- **Defining mechanism for public information sharing**

There is no established mechanism by way donors can share information to each other. However, sharing information is the norm. Individual analytical work done by each donor is usually shared with other donors. With more and more donors come together for a joint approach, a more established mechanism is perhaps underway. NAC needs to encourage and lead this process.

6.4 Improving Management for result

- **Defining a mechanism to use and generate strategic information for improved decision making and program planning**

According to the Three Ones Principles, one of the requirements for a strong national AIDS action framework is to demonstrate that it is evidence informed (UNAIDS, 2003). A critical question is whether the country has an established mechanism to use and generate strategic information for improved decision making and programme performance. Paris survey suggested that translating evidence on results into process of policy improvement remains a major challenge (OECD, 2006).

The Indonesian AIDS response has demonstrated its commitment to managing for results by development of a solid operational plan with clear targets and with a set of indicators to measure its progress. The country has also adopted a unified monitoring and evaluation system to track the progress. However, the challenge remains to assess to what extent the information generated from the system has been used for improving performance and for planning purpose. Is there adequate investment made toward making analytical work to base the development of the plan.

Experience from the Latin American countries have shown that with a comprehensive database on AIDS, they have been able to project future requirements, set priorities for the most cost-effective programme interventions; and direct resources to reach most at risk population that can have an impact to the AIDS epidemic (McGreevy, 2003).

In a recommendation made to the World Bank, Indonesia needs to start undertaking economic and institutional analysis related to the AIDS epidemic as the burden of financing, planning and executing the national response is considerable (Elmendorf, 2005).

Recommendation: Having a unified M&E system is not the end result. There is a need for NAC and its implementing partners / donors to discuss how the current unified M&E system has supported an improved decision making and programme planning and how it could be improved

6.5 Improving Mutual Accountability

- **Defining a mechanism for public accountability toward improving effectiveness in aid delivery**

The Paris survey confirmed the effort to improve mutual accountability at country level has just started. Government of recipient country needs to lead this discussion and jointly develop mechanism for all stakeholders to hold themselves accountable for achieving the development targets (OECD, 2006).

Accountability mechanism can provide constructive assessment to help improve service delivery at country level (Collins, 2008). In the global AIDS response, the GTT report highlighted that accountability has been focused more on upward-accountability such as to funding partners and rarely on down-ward accountability such as to beneficiaries. Existing country mechanism for public accountability can be utilized, such as through the parliaments (UNAIDS, 2005b).

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17. Prof. DN Wirawan, PAC Bali

Annex 1: Guiding questions for analysis

Questions	Issues
Improving Ownership:	
<ul style="list-style-type: none"> • Setting the Agenda 	
Country	
<p>Question:</p> <p>To what extent country has exercised its leadership to set the agenda of national AIDS response</p>	<p>NAC Governance</p> <p>Three Ones</p>
Donor	
<p>Question:</p> <p>To what extent AIDS donor is supporting partner-country in developing the leadership capacity to set the agenda of the national AIDS response</p>	<p>Capacity Development Strategy</p>

Questions	Issues
Improving Alignment	
<ul style="list-style-type: none"> • Alignment to national plan • Use of country's system 	
Country	
<p>Question:</p> <p>To what extent partner country has delivered a comprehensive policy and plan to convince AIDS donors to align to its policy and plan</p>	<p>National Policy & Commitment</p> <p>Costed operational plan</p>
<p>Question:</p> <p>To what extent partner country has strengthen its system to convince AIDS donors to use its existing programme, administrative and financial management</p>	<p>System and management of national AIDS response</p>
Donor	
<p>Question:</p>	

To what extent AIDS donor is willing to align its programme support to the national policy and plan	Donors' alignment strategy Donors' planning & project cycle
Question: To what extent AIDS donor is willing to use its existing programme, administrative and financial management in channeling their support	Use of country's existing management system for AIDS

Questions	Issues
Improving Harmonization	
<ul style="list-style-type: none"> • Presence of common arrangement • Use of country system • Sharing information 	
Country	
Question: To what extent partner-country is able to provide AIDS donors with clear complementarity plan to encourage harmonized efforts?	Complementarity plan
Donor	
Question: To what extent AIDS donors are willing to develop practices of common arrangements?	Practices of common arrangement (Joint Analytical work, Joint Review, etc)
Question: To what extent AIDS donors are simplifying their procedures at operational level	Practices of procedures (e.g. for reporting)
Question: To what extent AIDS donors are providing public information for coordination purposes	Practices of sharing information

Questions	Issues
Improving management for results	
Country	
<p>Question:</p> <p>To what extent partner-country is able to develop a common monitoring and evaluation framework to generate strategic information for improved decision making and programme planning?</p>	<p>M&E system</p> <p>Use of M&E information</p>
<p>Question:</p> <p>To what extent partner-country is able to produce results-oriented framework that monitor progress against a clear set of indicators and targets?</p>	<p>Costed operational plan with targets and indicators</p>
Donor	
<p>Question:</p> <p>To what extent AIDS donors are supporting its partner-country to develop results-oriented reporting and framework that can be linked to their country programming and resources?</p>	<p>Strategy to support M&E system</p>
<p>Question:</p> <p>To what extent AIDS donors are supporting a common monitoring and evaluation framework to generate strategic information for improved decision making and programme planning?</p>	<p>Strategy to support common M&E system for programme planning</p>

Questions	Issues
Improving mutual accountability	
Country	
<p>Question:</p> <p>To what extent partner-country has developed framework for mutual accountability on making aid more effective</p>	<p>Mutual accountability framework</p>
Donor	
<p>Question:</p> <p>To what extent AIDS donors are supporting partner-country in developing framework for mutual accountability on making aid more effective?</p>	<p>Support for mutual accountability framework</p>

Annex 2:

Source: National AIDS Commission (NAC), 2005. National Action Framework (2005 -2007). Jakarta: NAC

The Indonesian National AIDS Strategy 2003 – 2007

The first National HIV/AIDS Strategy was formulated and put into action in 1994. The increasing prevalence of HIV, and the shift to a pattern of a concentrated epidemic with IDU as an important mode of transmission was one of the main drivers for the revision of the Strategy in 2003 further ratified a National HIV/AIDS Strategy for the period 2003-7 (StraNas 2003-7), aiming to reduce transmission and improve the quality of life of people already infected or affected by HIV. The Priority Areas of the National HIV/AIDS Strategy include:

HIV/AIDS Prevention	Ensure that everyone can protect themselves against HIV infection, and avoid transmission to others
Care, Treatment and Support for PLHA	Alleviate the suffering caused by HIV/AIDS and prevent further HIV infections, and to improve the quality of life of PLHA
HIV/AIDS and STI Surveillance	Obtain information on the magnitude, distribution and trends of HIV/AIDS and STI transmission, which can be used in formulating HIV/AIDS prevention policy and activities
Operational Studies and Research	Carry out operational studies and research to get information that will help to improve the quality of HIV/AIDS prevention programmes, as well as to mitigate some of the negative impacts of HIV infection on individuals and the community, and improve the quality of life for PLHA
Enabling Environments	Pass legislation that will create an environment that fully supports the implementation of HIV/AIDS prevention
Multistakeholder coordination	Harmonize and integrate the HIV/AIDS Prevention policies and activities of government agencies, the private sector/business community, NGOs and the Community in order to be able to achieve the desired objectives effectively and efficiently
A sustainable response	Guarantee a sustainable response to HIV/AIDS at all levels of administration through high commitment and strong leadership, with the information and resources to support it

Annex 3:

Source: National AIDS Commission (NAC), 2005. National Action Framework (2005 -2007). Jakarta: NAC

The Indonesian National Action Framework 2005 – 2007**Super goals:**

To prevent and limit the spread of HIV and improve the quality of life for people living with HIV/AIDS so as to alleviate the socio-economic and health impacts of the epidemic on the people of Indonesia.

Medium term objectives:

Increased capacity to halt and begin to reverse the spread of HIV/AIDS infection among core transmitters and in areas of concentrated epidemic transmission. This would be measured by increased coverage among these populations with HIV/AIDS/STI prevention and care services including harm reduction programming; the NAC Secretariat fully operational at national and all other levels functional in priority provinces and districts; and, the Strategic Plan, 2007-2012 completed and linked to the Poverty Reduction Strategy.

The five priority areas of the Action Framework are:

1. Individual risk of sexual transmission of HIV reduced
2. Individual risk of HIV transmission among injecting drug users and sexual transmission to their partners reduced
3. Awareness of general population, particularly young people, increased of their vulnerability to HIV/AIDS infection and discriminatory behaviours towards PLWHA
4. Access and quality of care, treatment, and support for people living with HIV/AIDS improved with a focus on increasing VCT, treatment for OI and community based care and support
5. Capacity to prioritise and allocate resources for HIV/AIDS strengthened through operationalisation of the '3 ones' framework at national, province and district levels

Annex 4:

Source: National AIDS Commission (NAC), 2005. National Action Framework (2005 -2007). Jakarta: NAC

Overview of AIDS Donors in Indonesia (2003-2007)

USAID

The United States Agency for International Development (USAID) provides its assistance for the Indonesian AIDS response under a cooperative agreement with Family Health International through Aksi Stop AIDS (ASA) project.

Goal: To protect the health of the most vulnerable women and children in Indonesia" through "support activities to ensure that STI/HIV/AIDS prevention and services remain accessible, available, and of high quality. ASA strategies and activities are based on USAID Indonesia HIV/AIDS Expanded Response Strategy 2002 – 2007 and the Government of Indonesia's AIDS National Strategy. The focus areas are;

- Increased risk reduction behavior and practices among individuals most at risk for HIV and sexually-transmitted infections
- Strengthened quality, accessibility and utilization of prevention, care and treatment services for individuals most at risk for STI/HIV/AIDS
- Enhanced capacity and quality of Government of Indonesia HIV/STI surveillance systems and their use in decision making
- Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses
- Increased leveraging of programmatic interventions and financial resources.

ASA works collaboratively in 10 provinces through and with the HIV/AIDS Commissions at Provincial and District levels. These include: Papua, Maluku, North Sulawesi, Riau, North Sumatra, South Sumatra, DKI Jakarta, West Java, Central Java and East Java. The ASA team comprises 81 staff, 28 of whom are seconded to the NAC and NAC decentralised level. ASA also has 5 provincial offices with 10 programme officers working as integral members of the NAC teams at these levels and manages over 100 grant or sub-agreements with Indonesian provider organizations throughout these locations.

AusAID

Australian Agency for International Development (AUSAID) has provided its assistance to the Indonesian AIDS response through a sub-contract agreement with GRM International. GRM launched the Indonesia AIDS Prevention and Care Project (IHPCP), running from 2002 to 2007

Indonesia HIV/AIDS Prevention and Care Project (IHPCP) is consistent with the National HIV/AIDS Strategy and the new AUSAID strategy framework which aims to support improved economic management; help strengthen the institutions and practices of democracy; enhance security and stability; and help to increase the accessibility and quality of basic social services, particularly in education and health.

The project goal is to reduce transmission and vulnerability to HIV/AIDS and minimise the impact of the epidemic on individuals and society and the end of project objective is *To facilitate an expanded multi-sectoral response to HIV/AIDS in selected provinces and districts. The component objectives include:*

- To strengthen the capacity of the NAC, provincial and district NACDs, and NGOs for strategic planning, coordination and policy development.
- To assist relevant GOI, civil society and private sector partners to reduce the risk of sexually transmitted HIV among identified population groups.
- To assist relevant GOI, civil society and private sector partners to reduce the risk of HIV transmission through injecting drug use using a public health approach.
- To assist relevant GOI, civil society and private sector partners to improve the quality and utilisation of care, support, and treatment for People Living with HIV/AIDS (PLHA) and vulnerable population groups.
- To ensure efficient and effective management of the Project to achieve planned outcomes.

IHPCP is operational at national level and in 6 provinces: Bali, DKI Jakarta, West Java, Papua, South Sulawesi and Nusa Tenggara Timur. Approximately 55 staff are now directly contracted with 6 Provincial offices and 11 staff seconded to HIV/AIDS COMMISSIONS at national and decentralised levels.

The Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM)

Indonesia has been successful for both round 1 and 4 of the GFATM. The Principal Recipient for the GFATM is the Ministry of Health, Directorate Directly Transmitted Disease Control with the division of Communicable Disease Control (CDC), providing overall programme management support as well as secretariat support to the Country Coordinating Mechanism (CCM).

Priority areas for the GFATM activities, allocation mostly through public sector providers include:

Round 1

- Implement programs by multi-sector partners, non-governmental organizations and civil society
- Develop specific target information, education and communication materials for specific beneficiaries
- Improve the quality assurance of care, support and treatment of people living with HIV/AIDS
- Improve capacity building at national and local levels
- Improve the surveillance, monitoring and evaluation system

Round 4

- Provide appropriate care, treatment and support for PLWHA (in 17 provinces)
- Prevent HIV infection in core transmission groups including CSWs, IDUs and Waria
- Prevent HIV infection among vulnerable men through workplace programmes in targeted industries

German Development Cooperation (KFW)

German development assistance was negotiated in 1993 - 4 and has been delivered in Indonesia since 1995 through DKT, the counterpart being the Ministry of Health. DKT carries out research-based behavior change campaigns, which have over the last 8 years, increased awareness and use of condoms. DKT considers that the most effective way to reach Indonesia's large population with educational messages is through the mass media. DKT's program and distribution nationwide is largely through a commercial distributor with offices in 20 cities. This distributor covers the commercial trade (pharmacies and supermarkets). DKT's program has reached a 90% market distribution as well as the majority of non-commercial outlets (in hotspots) in the country.

UN Joint Action Programme (UN JAP) 2003-2007

The UN System supports Indonesia with the national response. The UN Common Country Assessment (CCA) identifies HIV/AIDS as a challenge to human development in Indonesia.

The purpose of the UN Joint Action Programme is to support the GoI to implement the National HIV/AIDS Strategy 2003-2007, in order to limit the spread of HIV, improve the quality of life of PLHIV and alleviate the socio-economic impact. Achievement of this purpose will contribute in turn to the achievement of Indonesia's international development commitments. The NAC Secretariat values the UN JAP as it provides a concept map of the UN response, and has facilitated the matching of UN resources to increasing the response from key sectors.

In order to support the national HIV/AIDS programmes related to prevention, care & support, and other technical areas, the UN system will provide assistance in four crosscutting areas. A fifth strategic area will be management of the UN system response:

1. Support for technical guidelines and national expansion of prevention, care and support services
2. Capacity building support for national actors
3. Support to NAC for national leadership, governance and policy development
4. Support for strategic information generation and analysis
5. Support for the management of the UN response

Indicators of Progress

To be measured nationally and monitored internationally

OWNERSHIP		TARGET FOR 2010
1	<i>Partners have operational development strategies</i> — Number of countries with national development strategies (including PRSs) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets.	At least 75% of partner countries have operational development strategies.
ALIGNMENT		TARGETS FOR 2010
2	<i>Reliable country systems</i> — Number of partner countries that have procurement and public financial management systems that either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	<p>(a) Public financial management — Half of partner countries move up at least one measure (i.e., 0.5 points) on the PFM/ CPIA (Country Policy and Institutional Assessment) scale of performance.</p> <p>(b) Procurement — One-third of partner countries move up at least one measure (i.e., from D to C, C to B or B to A) on the four-point scale used to assess performance for this indicator.</p>
3	<i>Aid flows are aligned on national priorities</i> — Percent of aid flows to the government sector that is reported on partners' national budgets.	Halve the gap — halve the proportion of aid flows to government sector not reported on government's budget(s) (with at least 85% reported on budget).
4	<i>Strengthen capacity by co-ordinated support</i> — Percent of donor capacity-development support provided through co-ordinated programmes consistent with partners' national development strategies.	50% of technical co-operation flows are implemented through co-ordinated programmes consistent with national development strategies.
5a	<i>Use of country public financial management systems</i> — Percent of donors and of aid flows that use public financial management systems in partner countries, which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	PERCENT OF DONORS
		Score* Target
		5+ All donors use partner countries' PFM systems.
		3.5 to 4.5 90% of donors use partner countries' PFM systems.
		PERCENT OF AID FLOWS
		Score* Target
5+ A two-thirds reduction in the % of aid to the public sector not using partner countries' PFM systems.		
3.5 to 4.5 A one-third reduction in the % of aid to the public sector not using partner countries' PFM systems.		
5b	<i>Use of country procurement systems</i> — Percent of donors and of aid flows that use partner country procurement systems which either (a) adhere to broadly accepted good practices or (b) have a reform programme in place to achieve these.	PERCENT OF DONORS
		Score* Target
		A All donors use partner countries' procurement systems.
		B 90% of donors use partner countries' procurement systems.
		PERCENT OF AID FLOWS
		Score* Target
A A two-thirds reduction in the % of aid to the public sector not using partner countries' procurement systems.		
B A one-third reduction in the % of aid to the public sector not using partner countries' procurement systems.		
6	<i>Strengthen capacity by avoiding parallel implementation structures</i> — Number of parallel project implementation units (PIUs) per country.	Reduce by two-thirds the stock of parallel project implementation units (PIUs).
7	<i>Aid is more predictable</i> — Percent of aid disbursements released according to agreed schedules in annual or multi-year frameworks.	Halve the gap — halve the proportion of aid not disbursed within the fiscal year for which it was scheduled.
8	<i>Aid is untied</i> — Percent of bilateral aid that is untied.	Continued progress over time.

HARMONISATION		TARGETS FOR 2010
9	<i>Use of common arrangements or procedures</i> — Percent of aid provided as programme-based approaches.	66% of aid flows are provided in the context of programme-based approaches.
10	<i>Encourage shared analysis</i> — Percent of (a) field missions and/or (b) country analytic work, including diagnostic reviews that are joint.	(a) 40% of donor missions to the field are joint.
		(b) 66% of country analytic work is joint.
MANAGING FOR RESULTS		TARGET FOR 2010
11	<i>Results-oriented frameworks</i> — Number of countries with transparent and monitorable performance assessment frameworks to assess progress against (a) the national development strategies and (b) sector programmes.	Reduce the gap by one-third — Reduce the proportion of countries without transparent and monitorable performance assessment frameworks by one-third.
MUTUAL ACCOUNTABILITY		TARGET FOR 2010
12	<i>Mutual accountability</i> — Number of partner countries that undertake mutual assessments of progress in implementing agreed commitments on aid effectiveness including those in this Declaration.	All partner countries have mutual assessment reviews in place.

Important Note: In accordance with paragraph 9 of the Declaration, the partnership of donors and partner countries hosted by the DAC (Working Party on Aid Effectiveness) comprising OECD/DAC members, partner countries and multilateral institutions, met twice, on 30-31 May 2005 and on 7-8 July 2005 to adopt, and review where appropriate, the targets for the twelve Indicators of Progress. At these meetings an agreement was reached on the targets presented under Section III of the present Declaration. This agreement is subject to reservations by one donor on (a) the methodology for assessing the quality of locally-managed procurement systems (relating to targets 2b and 5b) and (b) the acceptable quality of public financial management reform programmes (relating to target 5a.ii). Further discussions are underway to address these issues. The targets, including the reservation, have been notified to the Chairs of the High-level Plenary Meeting of the 59th General Assembly of the United Nations in a letter of 9 September 2005 by Mr. Richard Manning, Chair of the OECD Development Assistance Committee (DAC).

***Note on Indicator 5:** Scores for Indicator 5 are determined by the methodology used to measure quality of procurement and public financial management systems under Indicator 2 above.