***Strengthening Indonesia’s health workforce through partnerships***

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**Abstract**

Indonesia faces critical challenges pertaining to human resources for health (HRH). These relate to HRH policy, planning, mismatch between production and demand, quality, renumeration, and mal-distribution. Recognizing that HRH partnerships are fundamental to achieve Indonesia’s goal of Universal Health Coverage (UHC), in 2010 the government initiated multi-stakeholder coordination for HRH, using the Country Coordination and Facilitation (CCF) approach. The process requires committed engagement and coordination of relevant stakeholders to address priority health needs. Consistent with Indonesia’s decentralized health system, since 2011 local governments also started establishing provincial CCF committees and working groups for HRH development. Through this multi-stakeholder approach with high level government support and leadership, Indonesia was able to carry out HRH planning by engaging 164 stakeholders. Multi-stakeholder coordination has produced positive results in Indonesia by bringing about a number of innovations in HRH development to achieve UHC, fostered partnerships, attracted international attention, and galvanized multi-stakeholder support in improving the HRH situation. This approach also has facilitated mobilizing technical and financial support from domestic and international partners for HRH development. Applying the multi-stakeholder engagement and coordination process in Indonesia has proved instrumental in advancing the country’s work to achieve Universal Health Coverage and the Millennium Development Goals by 2015.

1. **Introduction**

Indonesia is one of the most populous countries in the world, with a population of 234 million. The country consists of approximately 17,000 islands, situated in a climatic disaster-prone region of Asia. About 60% of the population lives on Java Island which covers only around 7% of the country’s total land area. The country is counted as low-middle income country [[1](#_ENREF_1)]. Because of Indonesia’s particular geographic, demographic, socio-cultural diversity, and economic situations, its health system faces serious challenges. After decentralization in 2001, the new health system is now empowering local governments to manage their health services, including the management of Human Resources for Health (HRH) [[2](#_ENREF_2)].

The Indonesian health system is facing critical HRH challenges [[3](#_ENREF_3)]. The World Health Report 2006 [[4](#_ENREF_4)] included Indonesia as one of 57 countries facing a crisis level shortage of HRH. The HRH crisis level shortage impedes the progress that these countries can envisage for strengthening their health systems to be able to provide equitable access to essential and life-saving primary health care services. The HRH shortages pose serious obstacles for attaining the health-related Millennium Development Goals (MDGs) and Universal Health Coverage (UHC). The most critical HRH challenges in Indonesia include: inadequate quantity and quality of some essential cadres, mismatch between production and demand, and mal-distribution between urban, rural, and remote areas. Deficient information hampers HRH policy development and planning efforts. Other challenges include poor retention strategies, particularly due to low levels of remuneration [[5](#_ENREF_5)].

Indonesia’s average number of HRH per 100,000 population is below the minimum threshold level required for effective achievement of the health-related MDGs and UHC [[6](#_ENREF_6)]. The Health System Performance Assessment 2004 indicated that Indonesia suffers from mal-distribution and a shortage of certain kinds of essential HRH which has lowered community access to quality health workers and to quality health services. In 2008, the country had 7.73 specialists, 26.3 general physicians, 7.7 dentists, 43.75 midwives, and 157.75 nurses per 100,000 population [[3](#_ENREF_3)]. Most of the health workforce is concentrated in Java Island and in big cities, leaving rural and hardship areas underserved [[2](#_ENREF_2)]. Hospitals suffer from considerable shortages of nurses and other mid-level cadres [[8](#_ENREF_8)]. Community health centers face severe shortages of all HRH cadres except nurses [[9](#_ENREF_9)]. It is estimated that an additional 11,000 midwives are needed to serve in rural areas [[10](#_ENREF_10)]. HRH educational institutions increased in number in recent years but the quality of education is questionable. Among the country’s HRH educational institutions, only around one-third are accredited [[11](#_ENREF_11)]. The lack of data is a challenge for decision-makers in Indonesia for HRH policy making, program planning, implementation, monitoring, and evaluation. HRH migration across regions within Indonesia and internationally is another critical challenge [[12](#_ENREF_12)]. Furthermore, low government spending on the health sector is another challenge [[13](#_ENREF_13)]. Domestic and international HRH migration contribute significantly to this national crisis.

Poor health indicators are closely linked to HRH shortages and maldistribution in Indonesia. Despite some significant improvements, Indonesia is unlikely to achieve MDGs 5 and 6, mainly due to HRH challenges, especially in remote areas. [32]

With this backdrop, the Indonesian Ministry of Health (MoH) explored innovative approaches and processes that could effectively help in addressing the HRH challenges. While reviewing global experiences and best practices, the MoH found the Country Coordination and Facilitation (CCF) [[14](#_ENREF_14)] approach by the Global Health Workforce Alliance (the Alliance) [[15](#_ENREF_15)] most relevant to its context and needs.

1. **Methods**

*The Country Coordination and Facilitation approach for establishing HRH multi-stakeholder coordination in Indonesia*

It has been globally acknowledged that HRH is a multi-sectorial and multi-dimensional issue and that any single actor or single action cannot resolve a crisis level shortage of HRH. An inclusive approach to address the underlying challenges is required. More specifically, effective solutions depend on collaboration among the related players, actors, and stakeholders at global, regional, and country levels [[15](#_ENREF_15)]. The Country Coordination and Facilitation (CCF) approach builds on a partnership of the key stakeholders which constitute the foundation of Indonesia’s National Health System [[16](#_ENREF_16)].

In response to the urgent need for enhanced coordination around an HRH agenda, the Alliance, through a consultative process, developed a document ‘Country Coordination and Facilitation - Principles and Process on HRH’ that endorses an integrated health workforce response. Since 2009, as a means of tackling the critical issues related to HRH, the Alliance has advocated and promoted implementation of the multi-stakeholder coordination approach in countries experiencing crisis level shortages of HRH as a way to coordinate all of the relevant stakeholders. HRH stakeholders typically include: ministries of health, education, labor, finance, planning, and other related ministries, as well as regulatory bodies, the private sector, professional associations, NGOs and civil society organizations, and multilateral and bilateral development agencies [[5](#_ENREF_5)].

The CCF approach highlights the need for the inclusive engagement and coordination of relevant stakeholders, with the Ministry of Health (MoH) playing a lead role, while building and nurturing close links with other coordination mechanisms for health system strengthening as well as those involved in key national health programs. Multi-stakeholder coordination facilitates developing and implementing evidenced-based comprehensive HRH strategies and plans as integral components of the national health policy and the development agenda towards attaining the MDGs and UHC [[17](#_ENREF_17)].

In 2010 the Alliance oriented Indonesia to the CCF principles and processes and provided catalytic support through the World Health Organization (WHO) Indonesia country office to establish a multi-stakeholder coordination mechanism [[18](#_ENREF_18)]. Indonesia adopted this approach and established a multi-stakeholder committee called ‘Tim Koordinasi dan Fasilitasi Pengembangan Tenaga Kesehatan (TKFPTK)’ or ‘Country Coordination and Facilitation committee’ for HRH [[19](#_ENREF_19)]. The high level political support in establishing the HRH coordination process remained extremely significant. The Minister of Health communicated to the Coordinating Minister of People’s Welfare (MoPW) the need for multi-stakeholder collaboration to address the HRH issues not only at the technical level but most importantly at the policy-making level. Considering this as a priority need, the MoPW held a high level coordination meeting to agree on the need to set up a CCF committee. This resulted in the institutionalization of the CCF Committee by the MoPW, which provided leadership ensuring a functional and efficient coordination process [[17](#_ENREF_17)].

*Structure and roles of the CCF committee in Indonesia*

In the high level meeting with stakeholders, the CCF committee structure was outlined and roles were defined. Members of the committee from public and private sectors were selected based upon the stakeholder analysis of structures, functions, and potentials for related constituencies [[20](#_ENREF_20)]. The Indonesia CCF Committee at central level is comprised of 164 members representing various stakeholder constituencies, including: the coordinating Ministry of People’s Welfare, Ministry of Home Affairs, Ministry of Health, Ministry of Education and Culture, Ministry of Finance and Legislative Body, Ministry of Labour and Transmigration, Ministry of State Apparatus, Ministry of Foreign Affairs, National Civil Servant Board, Armed Forces, Police Department, health professional organizations, associations of health educational institutions, associations of health care organizations, and partners, including related international agencies [[21](#_ENREF_21)]. In March 2011, the Coordinating Minister issued the Decree of the CCF Committee to establish formally the country’s commitment and to adjust the new nomenclature of the Ministerial units [[16](#_ENREF_16)].

The CCF Committee consists of a Steering Subcommittee, an Implementing or Executive Subcommittee, three task forces or ‘working groups,’ and a Secretariat (illustrated in figure 1), whose functions are detailed below:

* The Steering Subcommittee is responsible for directing and priority setting, strategic planning, as well as inter-sectorial coordination and resource mobilization for HRH development.
* The Executive Subcommittee facilitates and coordinates all stakeholders in formulating, implementing, and evaluating the strategic planning.
* Working Group one facilitates the planning, utilization, and distribution of the health workforce.
* Working Group two is responsible for facilitating the production of HRH.
* Working Group three facilitates supervision, monitoring, control, and evaluation of HRH, the functioning of the regulatory body of the health workforce called Majelis Tenaga Kesehatan Indonesia (MTKI) or National Health Workforce (Professional) Board and the establishment of Majelis Tenaga Kesehatan Provinsi (MTKP) or Provincial Health Workforce (Professional) Board, as well as continuing professional development.
* The HRH director of the MoH provides the Secretariat. The Secretariat is responsible to support the functioning of the Committee, advocate and build capacity among the HRH development stakeholders, and develop knowledge management in HRH development.

**Figure 1. Governance of the CCF Committee, Indonesia** [[16](#_ENREF_16)]



Indonesia’s decentralized health system is designed to empower local governments to manage their health services, including HRH, according to their needs. Building on the success of the national level CCF, in 2011 local governments were directed to establish provincial CCF committees and working groups, emphasizing coordinated and synergistic efforts in HRH development through the partnership process. By 2013, three provinces had established CCF committees. An additional five provinces are currently in the process of doing the same [[22](#_ENREF_22)].

In order to strengthen coordination and communication among stakeholders, Indonesia developed two guidelines [[16](#_ENREF_16), [19](#_ENREF_19)]:

1. Guidelines for the Organizational Structure of the CCF Committee, which contains the functions and coordinating mechanisms, and
2. Guidelines for the Establishment of Provincial level CCF and District HRH Working Group, which covers, among other aspects, consultation and knowledge management on HRH development.

*Functioning of the multi-stakeholder engagement and coordination process in Indonesia*

The CCF approach in Indonesia uses the following six process steps to tackle the HRH challenges:

1) HRH Coordination mechanism;

2) HRH Situation analysis;

3) HRH planning development;

4) Resource mobilization;

5) HRH plan implementation; and

6) Monitoring and evaluation of the HRH plan.

Coordination of the CCF is conducted through formal and informal forums. The formal forum uses regular meetings, such as those for the Executive Subcommittee, working groups, Secretariat, and plenary meetings, as well as well as national seminars involving all members of the CCF and other stakeholders where relevant. The informal forum uses an internet-based mailing list on a voluntary basis. To date, formal meetings at national level have been funded by the Government of Indonesia, the Alliance, and the WHO. Through its regular meetings, national workshops, and seminars the Committee carries out its functions including policy dialogue for developing and implementing the HRH plan [[20](#_ENREF_20)].

1. **Results and Discussion**

*HRH planning through the multi-stakeholder coordination approach*

One of the main tasks of the national CCF committee was to develop an HRH Long-Term Development Plan (The Plan) for 2011-2025 [[16](#_ENREF_16)].

The HRH planning process continued for two years, overseen by the Ministry of Health (MoH), and engaged 164 key stakeholders in HRH planning and decision-making [[22](#_ENREF_22)]. The planning process began in 2010 with an HRH situation analysis and identification of strategic issues. In 2011 policy dialogue among key stakeholders began and The Plan was drafted by the Working Group on HRH Planning and Management, with multi-sectorial coordination. In 2012 the a draft of The Plan was approved by the Ministers of Health, Education, and People’s Welfare and was disseminated to all stakeholders for further implementation.

The Plan addresses the following key HRH areas [[20](#_ENREF_20)]:

* Planning
* Production
* Utilization and management (utilization and management include recruitment, distribution, deployment, continuing professional and career development)
* Quality (quality includes competency certification, registration, and licensing)
* Supervision, monitoring, and evaluation of results at all levels.

Based upon the evidence collected during the HRH situation analysis, six strategies were developed for achieving well distributed, qualified heath workers by 2025 [[5](#_ENREF_5)]. These include:

1. Strengthening of regulation on HRH development and empowerment.
2. Strengthening of HRH needs planning.
3. Improvement and development of HRH production, i.e. education and training.
4. Improvement of HRH utilization, including equitable and just distribution, career development at all levels and across sectors, including the private sector and the international market. Special attention must be given to health workers working in remote areas, at country borders, on small outer islands, and in areas with special health problems.
5. Supervision and control of HRH quality.
6. Strengthening of HRH development resources: capacity building, HRH information systems, financing, and other support systems.

*Support to multi-sectoral HRH coordination*

An effective multi-sectorial approach for HRH planning and development in a country like Indonesia requires shared objectives and goals by stakeholders, which facilitates resource mobilization to support HRH development programs.

Through the multi-stakeholder coordination process, Indonesia has successfully mobilized support from domestic and international partners, public resources, and investments for HRH development needed to achieve UHC. Support has come from Ministries, in particular the Ministries of Home Affairs, Education and Culture, State Apparatus, Finance, and National Planning and Development [[14](#_ENREF_14)]. Catalytic support from the Alliance helped raise awareness which led to strengthening the coordination mechanism, advocacy for high level and partners’ support, and resource mobilization. Support from the WHO and the Asia-Pacific Action Alliance on Human Resource for Health (AAAH) assisted in HRH development. AusAid funds strengthened HRH planning and management, and JICA funds enabled development of a nursing career ladder system and in-service training. Within the last five years investments in HRH increased by almost 60% [[23](#_ENREF_23)]. Yearly budgets allocated for core activities in the 2010-2014 HRH action plan increased significantly [[24](#_ENREF_24)].

The operational cost of the consultation process, consisting of regular coordination meetings and a national annual conference, is approximately USD 15,000/year [[23](#_ENREF_23)], which is mainly supported by the MoH and the MoPW. For HRH activities, the Ministry of Education and Culture (MoEC) funding is 20% of the national budget while MoH funding is less than 3%. The collaborative approach mobilized the MoEC to share its budget to support some MoH programs, especially in HRH development. One of the programs supported in part by the MoEC was the distribution of internship doctors to district hospitals and community health centers for 3654 doctors in year 2012 and for 4974 doctors in year 2013 [[25](#_ENREF_25)]. Table 1 illustrates an overview of the support provided by various stakeholders, both in cash or in-kind.

**Table 1: Technical and monetary contributions by key stakeholders [35]**

|  |  |
| --- | --- |
| **Constituencies** | **Contribution** |
| Coordinating Ministry of People’s Welfare | * Lead the CCF process and coordinate with the MoH and other ministries on HRH planning and policy formulation.
* Harmonize inputs from stakeholders and other institutions on HRH development.
* Coordinate with the Ministry of Finance and Legislative Body for financial support and sustained commitment to implementing the HRH plan.
* Provide financial support for operational costs of the coordination process.
 |
| Ministry of Health  | * Technical lead in HRH Policy development and planning with the inputs of relevant stakeholders.
* Implement HRH plan with relevant stakeholders.
* Monitor HRH development and progress.
* Finance HRH activities and relevant processes.
 |
| Ministry of Home Affairs | * Provide inputs on HRH planning needs and requirements based on local needs.
* Along with armed forces, police department, and other stakeholders make recommendations regarding the supervision, monitoring, and control of HRH working at health facilities under its aegis.
 |
| Ministry of Education and Culture | * Policy formulation on HRH education.
* Carry out HRH education according to the national HRH plan.
* Collaborate with relevant stakeholders on quality assurance.
 |
| Ministry of Finance | * Approve budget plan on HRH development from each ministry and other government agencies.
* Provide financial support.
 |
| Other ministries and agencies: Ministry of Labor and Transmigration, KEMENPAN-RB, Ministry of Foreign Affairs, BKN, Armed Forces, Police Department | * Ministry of Labor and Transmigration provides inputs on HRH planning and requirements for migrant health workers and to the National Bureau on Placement and Protection of Indonesian HRH or Badan Nasional Penempatan dan Perlindungan Tenaga Kerja Indonesia (BNP2TKI).
* Other ministries, Armed Forces, and Police Department provide recommendations for HRH planning and requirements for their respective health care facilities under their aegis.
* KEMENPAN-RB verifies the provision of civil servant HRH formation (vacancies) in the public sector.
* BKN verifies the fulfillment or placement of HRH civil servant vacancies in the public sector.
 |
| Regulatory bodies  | * Support the implementation of policies on HRH planning and HRH production with quality standards.
* Support financial requirements (financial commitment).
 |
| Medical Council, (Other) HRH Boards, health professional organizations, association of HRH educational institutions, association of health services organization | * Provide information on professional and competency standards relevant to the HRH planning policy, HRH planning, and requirements, etc.
* Provide information on number and qualification of HRH required for planning purposes.
* Provide information on resources for educational purposes, number of graduates, etc.
* Health professional organizations and the Ministry of Health of the Republic of Indonesia make recommendations on the kind, number, qualification or competency of HRH to be produced to fulfill the HRH needs.
* Indonesian Medical Council, MTKI, and health professional organizations provide information on HRH distribution, registration, and continuing professional development as an input for policy formulation on HRH management in general.
 |
| Civil society organizations  | * Provide information on HRH performance.
* Contribute HRH advocacy based upon needs.
 |
| Private sector | * Provide inputs on HRH needs (quality and quantity, distribution, etc.).
 |
| Asia-Pacific Action Alliance on Human Resource for Health (AAAH) | * Provided opportunity for sharing knowledge and experiences with other countries in the region.
* Provided funding support for conference attendance.
* Linked with other countries.
 |
| Global Health Workforce Alliance  | * Provided catalytic funding support for implementation of the CCF approach.
* Provided advice and support to establish the multi-stakeholder coordination process, HRH situation analysis, planning, and its implementation.
* Provided opportunities to share examples of success at the global level.
* Conducted an evaluation of the CCF implementation and its added value.
 |
| World Health Organization  | * Provided funding support for development of the Indonesia country profile of HRH.
* Provided technical support and information on HRH production, deployment, management, and monitoring.
 |

*Multi-sectoral HRH coordination towards achieving Universal Health Coverage*

Strong political will and investments in HRH at local, national, and international levels are key to the success of Indonesia’s partnership process. This synergy is fundamental to achieving Universal Health Coverage (UHC). The National Health Insurance program as part of the Universal Health Coverage policy was officially launched by the President of Indonesia on December 31, 2013 and started on January 1, 2014.

The country expects to achieve UHC by 2019 through an integrated health insurance scheme, following the 2012-2014 roadmap for HRH development to support UHC (Figure 2). The multi-stakeholder coordination approach has accelerated interventions for HRH education and training, distribution, planning, implementation, and monitoring and evaluation, all essential to produce required HRH numbers and quality to achieve UHC [[22](#_ENREF_22)].

**Figure 2: Framework for roadmap of HRH development to support UHC** [[26](#_ENREF_26), [27](#_ENREF_27)]



*Key benefits and achievements of the multi-sectoral coordination in Indonesia*

Multi-stakeholder coordination through the CCF Committee has remained enormously instrumental in addressing Indonesia’s underlying HRH challenges and has facilitated significant activities since 2010. Indonesia’s Country Plan 2011 reported progress made in the 2010 action plan, highlighting the following achievements made through strengthened stakeholder coordination [[28](#_ENREF_28)]:

1. Produced HRH country profile and situational analysis, determining strategic issues and main policies for the development of the national strategic plan on HRH.
2. Mapped existing numbers of health workers in public health facilities and estimated the required health personnel.
3. Developed National HRH plan 2011-2025 that is linked with the national health policy and provides a roadmap to achieve UHC through action in HRH.
4. Developed Grand Design for improved HRH education (pre-service training) and in-service training.
5. Facilitated a joint agreement between three ministries (MoH, Ministry of Home Affairs (MoHA), and MoEC) on HRH development. The agreement is between 13 medical schools, 4 dental schools, and 56 heads of districts or city mayors to assure better educational facilities for medical residents, provide training sites for residencies, secure funding for training and incentive schemes, and improve medical and dental services for communities in remote areas.
6. Facilitated special assignments for health workers (such as a contract scheme and special recruitment for civil servants) to serve in remote, underserved, country border areas, and on small outer islands, including the assignment of senior residents to rural district hospitals. By year 2013, the number of contracted health workers was 46,275 (doctors, dentist, and midwives) and 3000 medical doctors, including specialists, recruited as civil servants. This resulted in a decrease from 30% in 2006 [[7](#_ENREF_7)] to 9% in 2013 [[6](#_ENREF_6)] of the percentage of community health centers not having medical doctors.
7. Increased numbers of HRH registered and certified by the National Profession Board. Since the establishment of this board in 2011, this institution has registered 440,662 health workers (excluding doctors and dentists) [[29](#_ENREF_29)].
8. Facilitated scholarships for medical specialists and nurse training with service bonding in rural hospitals. Since 2008, the number of nurses who received scholarships for Diploma 4 training has increased continuously from 110 nurses to 1,754 in 2012. The number of medical doctors who received scholarships for specialist training programs by 2013 was 4,746, and in 2014 scholarships will be provided for approximately 1,300 medical doctors [[29](#_ENREF_29)].
9. Incorporated principles of the WHO Code of Practice on the International Recruitment of Health Personnel, adopted MoH regulations on the Recruitment of Indonesian Nurses to Work Abroad, assigned a national focal point department, and issued a monitoring report [[22](#_ENREF_22)].
10. Mobilized agreement on developing a national HRH observatory for effective evidence- building required for policy decisions and monitoring progress [[30](#_ENREF_30)].
11. Disseminated information through a national seminar on the Indonesian CCF, which resulted in an agreement to establish similar committees at province and district levels [[31](#_ENREF_31)].
12. Developed guidelines for establishing CCF committees at local level and provided support to the local governments accordingly.

*Added value of Indonesia’s multi-stakeholder coordination*

Based upon the achievements described above, the multi-stakeholder coordination approach has brought significant added value and advantage to the HRH agenda in Indonesia. Of greatest importance:

* The approach has raised awareness among the key stakeholders of the importance of integrated and synergistic action to improve the quantity, equitable distribution, and the quality of HRH across the country.
* The CCF committee has provided a coordination forum for policy dialogue among HRH- related stakeholders, including high level officials from all key ministries, decision-makers, academicians, professional organizations, and the private sector to meet, share information, and discuss important issues related to HRH. Previously such discussions were held in isolation, scattered, and sometimes with conflicting interests between sectors.
* The stakeholders in Indonesia now share the same priority agenda to achieve UHC and the MDGs, in which HRH is its significant component.
* The coordination process has led to better data collection and evidence-building with the multi-sectorial inputs required for decision-making, better planning, implementation, and monitoring of HRH development programs.
* The pathway of stakeholder engagement and coordination has resulted in evidence-based and comprehensive HRH planning with shared investment by the related sectors and stakeholders. This has led to increased support, including funding, to achieving goals.
* Through this approach, the joint initiatives by various sectors have enhanced access to skilled health workers in remote areas.
* The multi-stakeholder coordination mechanism at central level has become a model for establishing local level CCF committees in the provinces, districts, or cities, and has galvanized local commitments to HRH development.

An external evaluation of Alliance by Oxford Policy Management (OPM) in 2011 verified that Indonesia’s implementation of the CCF strategy was effective and brought value for money. Multi-stakeholder coordination has played a role in fostering partnerships and enhancing support, as well as attracting international attention to the serious need to improve the country’s HRH situation. It also facilitated high level commitment in Indonesia and enabled the MoH to obtain additional funds from the Ministry of Education and Culture together with a higher level of support for HRH from the Ministry of Finance [[5](#_ENREF_5)].

*Challenges of muti-sectoral coordination*

The multi-sectoral coordinationprocess in Indonesia is not without obstacles and challenges. Some critical challenges found in implementing the CCF process in Indonesia include:

* Frequent changes of leadership and representatives from various stakeholder constituencies.
* Different stakeholders have diverse views and concerns about the importance of HRH issues.
* Proactive and regular participation of some of the stakeholders was a limitation in ensuring fully-inclusive engagement.
* The private sector’s contribution tends to be less compared to public sectors.
* Commitment of the CCF team has varied, resulting in delays in decision-making or setting policies.
* Communication with a large number of stakeholders and keeping all on board has been a difficult process for the secretariat.
* Some stakeholders have inadequate quality of data on HRH development and management. In particular, the lack of well documented data of the private sector and grass-roots level presents a major hindrance in adequate planning and decision-making.
* Geographical barriers present challenges to establishing decentralizing coordination mechanisms for multi-stakeholder engagement.
* Potential sustainable financial and other resources have not yet been adequately identified and documented either at national and local levels or from other sources.
* The secretariat is run by a part-time staff and needs to be strengthened.

The CCF Secretariat attempts to overcome these obstacles through targeted coordination meetings, national conferences, and awareness-building on HRH issues for new stakeholder representatives [[20](#_ENREF_20)]. To improve HRH management capacity, the MoH, Ministry of State, and National Personnel Bureau conducted HRH planning workshops using a workload analysis approach for central, provincial, and district personnel. Respective stakeholders are made responsible to support, contribute to, and monitor the HRH plan implementation through regular meetings [[22](#_ENREF_22)] facilitated by the secretariat. To cope with the challenges of the sustainability of the CCF committee, the MoH needs to advocate continously with and for the stakeholders. Changes over time in executive and technical officials in various ministries and institutions make it essential that new leaders maintain HRH development as a priority issue.

*Remaining challenges of the current HRH situation in Indonesia*

Notwithstanding significant recent advancements in tackling the problem of health worker shortages in Indonesia, much still remains to be done to achieve equity of access to HRH and the process will be long and arduous. The country still suffers from a critical level shortage of health workers. Based on the trends in progress, by 2011 the density of health workers (doctors, nurses, and midwives) in Indonesia increased from 0.95 per 1000 population to 1.19 per 1000 population [33]. Despite good progress made for HRH development including recruitment of health workers through contract and special assigment schemes, civil servants for rural postings, bonding scholarships, and other policy formulations, in 2013 Indonesia continued to face an HRH crisis, as shown in Figure 3. With the population growth rate of 1.49% per annum, Indonesia needs to make additional efforts to achieve the targeted ratio of 2.63 health workers per 1000 population by the end of 2014.[34]

**Figure 3: Health Workforce Ratio Trend per 1000 population** [34].

The MoH continues to emphasize the need to redress the imbalance between urban and rural distribution in order to improve access to health workers. By 2013, the total ratio of medical specialists was slightly above target from 9 to 9.9 per 100,000 population. The ratio however, varies greatly by province - 1.6 per 100,000 population in East Nusatenggara Province to 52.8 per 100,000 population in DKI Jakarta province (Figure 4). Among 2,184 hospitals, approximately 29% remain without pediatricians, 27% lack obstetric gynecologists, 32% do not have surgeons, and 33% are without internists.[34]

**Figure 4: Distribution of Medical Specialists by Province per 100,000 population in 2013** [34].

1. **Conclusion**

The multi-stakeholder coordination approach has played a significant role in fostering collaboration, enhancing support, and attracting international attention towards the need to improve the situation of crisis level shortage of HRH in Indonesia. The approach has facilitated and galvanized high level political commitment and enabled the MoH to obtain additional funds together with a higher level of support for HRH. The process became a model for establishing similar local partnerships in all provinces, districts, and cities for promoting commitment to HRH development.

Within the last five years, through this approach, Indonesia has been able to improve HRH staffing levels by continuously increasing the availability of health workers, especially in remote areas, and by scaling-up education capacity for medical specialists, doctors, nurses, and midwives. These combined efforts contribute to the gradual improvement of the HRH situation and to reducing inequalities. Re-distribution of health workers from oversupplied to undersupplied areas remains the biggest challenge. The stakeholder forum acknowledged the urgency for a clear government regulation to support the local recruitment of health workers, innovative interventions for HRH deployment and retention, and the need for information-strengthening to address HRH re-distribution. Currently three ministries (MoH, MoHA, and the Ministry of State Apparatus) are working closely to issue a joint ministerial regulation to ensure that HRH planning and improvement of HRH distribution for public health services will be carried out by the local level governments.

Notwithstanding the remaining significant challenges to overcome, the multi-stakeholder engagement approach is facilitating the stakeholders to formulate shared HRH strategies and goals to achieve UHC and the MDGs by 2015, and beyond, with commitment from all partners to ensure the availability of adequate resources. It is also contributing to mobilizing technical and financial support from various sources, including public-private partnerships. Sustained and synchronized partners’ support is needed for continued and consistent HRH developments at national and local levels, in addition to in-country support from related sectors and stakeholders.

*Lessons Learnt*

Through the multi-stakeholder coordination approach more systematic and comprehensive HRH development exists in Indonesia due to:

* shared vision, ownership, and accountability through consolidated coordination and policy dialogue among key stakeholders,
* greater awareness about the importance of integrated and synergistic action to improve the quantity, equitable distribution, and quality of HRH,
* country ownership with high level commitment to increased financial inputs and policy support towards HRH,
* catalytic support promoting and fostering a comprehensive situational analysis and developing an evidence-based national HRH strategic plan, and
* integrating HRH in national health policies and plans to achieve both the MDGs and UHC.

**Box 1:**

**Recommendations based on lessons learnt**

* Countries can successfully carry forward their HRH agenda and improve their health workforce situation by applying the multi-stakeholder coordination approach.
* All countries, irrespective of their geographical or economic status can benefit from multi-stakeholder coordination to ensure and sustain UHC.
* Create formal and informal links between health-related coordination mechanisms.
* Continuously advocate for support from decision-makers to prioritize HRH in health sector policies to solicit commitments and increased investments.
* Improving information-sharing and policy dialogue among HRH stakeholders should be promoted in order to develop comprehensive HRH polices and plans with broad consensus, collective vision, harmonized roles, and shared accountability.
* Strengthen the health system by engaging and regulating the private sector, quality improvement, task-sharing, skills mixing, and scaling up HRH to address the problems of remote and rural areas towards achieving UHC.

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