SHIFT
Sustainable HIV Financing in Transition

Civil society programming through
a de-centralised budgeting system:

The case of Indonesia

At a glance	
Population	261,120,000 [5]
GNI per capita (US$)	3,400 [6]
HIV epidemic type	Concentrated
HIV prevalence	
Adults (15-49)	0.4% [7]
Men who have sex with men	25.8% [7]
Female Sex workers	5.3% [7]
People who inject drugs	28.8% [7]
Transgender	24.8 [7]
Domestic HIV expenditure (US$)	60,513,835 [8]
Int'l HIV expenditure (US$)	46,280,762 [8]
Domestic to int'l HIV expenditure ratio	1.3:1 [8]
Latest GF disbursement, HIV/AIDS (US$)	33,319,021 [9]
HIV prevention expenditure to KP	6.3% [8]

The issue

Indonesia's HIV response is heavily funded by international donors, accounting for 57 percent of to-tal HIV expenditures and 71 percent of key population prevention programming in 2014 [1]. The Global Fund is the biggest donor among them, accounting for 60 percent of international funding sources in the same year [1]. As the Government of Indonesia takes on increasing financial responsi-bility for its HIV response, the country will face several challenges, namely that budgetary analysis will become the responsibility of individual districts because of Indonesia's decentralised system of government. Meanwhile, district-level government processes are obscure and otherwise inaccessible to local civil society organizations (CSOs).

There are also concerns that the unique needs of key populations will not be given the attention they deserve during or after the transition [2]. Such programmes are typically led by CSOs in Indonesia and the extent of their role in the future of the response is uncertain because of ongoing service integra-tion.

Budget transparency and analysis at the local level will be essential to revealing situations where in-sufficient resources are allocated to addressing HIV or HIV resources are allocated inefficiently. De-centralisation in Indonesia requires that such efforts to advocate and build capacity of civil society tend to happen from the ground up, beginning at the village level—presenting a multifaceted challenge to which there is not yet a clear solution.

The context

Indonesia has the largest economy in Southeast Asia and has enjoyed robust growth for decades. Emerging from the 1997 economic crisis, Indonesia nearly doubled its GDP between 2001 and 2012. Poverty rates reduced by nearly 50 percent during this period, owing in part to the implementation of universal health coverage (UHC)—a scheme that has not been implemented evenly across its 34 provinces that span 6,000 islands [2].

Approximately 620,000 people are living with HIV in Indonesia, a population estimate that grew by 48,000 in 2016 [3]. Indonesia hosts one of the fastest growing HIV epidemics in the region and was one of the few countries to report an increase in new cases in 2014 [3]. In most of the country, the epidemic is concentrated among men who have sex with men (MSM), sex workers, and people who inject drugs (PWID). Among these four risk groups, sex workers are found to have the lowest HIV prevalence (5.3 percent) and PWID the highest (28.8 percent) [4].

Funding landscape

Indonesia's domestic funding to the HIV response increased threefold between 2003 and 2012, a period which saw a dramatic shift in political commitment and treatment scale-up [3]. During this time, domestic HIV expenditure grew from less than a quarter of total spending to about two-fifths. Revenue collection in Indonesia is centralised while expenditure is largely decentralised. According-ly, district governments contributed 15 percent of total domestic HIV investment in 2014 [8].

Like in many countries in the region, HIV expenditure is misaligned with disease burden. Sex between men accounted for 22 percent of new HIV cases in 2014, yet MSM only received 0.1 percent of HIV prevention expenditure [8]. Combined, key populations were allocated only one percent of HIV pre-vention expenditure. A 2012 breakdown of domestic vs. international expenditure by beneficiary population showed that of the insufficient investment in MSM programming, the Government of Indonesia contributed a meagre 0.3 percent [10].

Comparing investments and disease burdens across districts, one also finds misalignment. For exam-ple, the city of Bandung has a larger HIV epidemic than Semarang, and yet the budget allocation for HIV in Samarang is considerably larger. This is explained by a feature of Indonesia's HIV response that represents a crucial challenge: districts exercise a high level of autonomy and determine, inde-pendently, where to rank HIV as a priority. There is a palpable risk of jeopardizing the country's pro-gress in ending AIDS if districts continuously underinvest.

Financing mechanisms

Government spending on health in Indonesia happens through two channels: direct central govern-ment expenditure and transfer to sub-national expenditure. Three mechanisms exist to access direct central government expenditure: (1) a decentralisation fund whereby districts apply for funds to im-plement health activities in line with MoH; (2) a so-called support assignment fund for physical assets and infrastructure; and (3) grants for operational costs at the community health centre level for the provision of outreach and other health promotion services.

Meanwhile, sub-national expenditure typically happens in the context of national health pro-grammes and health system operational costs. Direct central government expenditure accounts for 40 percent of the national health expenditure and sub-national expenditure accounts for 11 percent [2]. Neither method of accessing government expenditure reveals clear opportunities for CSOs to re-quest funding.

Seknas FITRA

The Indonesian Forum for Budget Transparency (FITRA) was founded in 1999 as a non-profit organisa-tion that seeks to promote the responsible management of public finances in Indonesia through conducting budget analyses and advocacy at the national, subnational, and local levels in 13 provinces. Its mandate covers all areas of public financing, not only those related to health or HIV, and its mission is fundamentally about realizing people's sovereignty over the state budget.

FITRA analyses the planning, discussion, implementation, and evaluation stages of the budget pro-cesses to determine if commitments are being met. For example, if a programme is outlined in a national strategic plan but there is not a budget for that program, FITRA will create awareness of the misalignment and pressure the government to rectify it. Furthermore, FITRA works directly with re-gional legislatures to understand how underfunded sectors, such as health and education, could be more effectively targeted using existing funding mechanisms.

It began its work monitoring spending during general elections, analysing budget allocations and expenditures in the education sector, and monitoring of local budgeting processes in municipalities across the country. While the health sector has always been in its purview, its first major health-related initiatives included "Encourage Budget Transparency and Participation to Increase Budget Allocation for Education and Health through Jakarta's Parliamentary Caucus Enhancement" in 2007 and "Pushing for society involvement in pushing for HIV/AIDS responsive budget" in 2009. Its repu-tation as a reliable producer of research and rigorous analyses has grown, eventually gaining the sup-port of several regional and international donors such as Asia Foundation, Ford Foundation and HIVOS.

In 2017, Seknas Fitra was approached by the Indonesian AIDS Council to analyze 2 district level HIV budget as part of the Global Fund Sustainable HIV Financing in Transition (SHIFT) Program. Under this collaboration, FITRA worked to assess, at the sub-national level, the extent to which selected districts included key HIV interventions, including those that MoH committed to implement. This is an immense task as district-level government documents are obscure, often inaccessible, and the process must be repeated at each of the socio-politically diverse districts.

Budgetary analysis in two districts

Through this analysis, they found districts exercise a high level of autonomy and determine, independently, where to rank HIV as a priority. Analysis of the 2017 Bandung and Semarang budgets show misalignment between investments and disease burdens across districts. Both Bandung and Semarang fall under the highest HIV prevalence category in Indonesia, and yet the budget allocation for HIV in Semarang is considerably larger. In Bandung, we found there was not a single programme specifically targeted on prevention for key populations. In Semarang, though there were resources budgeted for key populations groups, many organizations either did not have the legal recognition to access these funds.

Furthermore, they found the funding mechanism in Indonesia to be overall problematic, as the kinds of assistance that would fund CSO-led health interventions (e.g., "grant expenditures" and "social assistance spending") are listed as components of "indirect expenditures", which is non-binding, unsustainable, and comes with no mandate.

Because of decentralisation, organisations that implement activities in more than one district are subject to the various institutional and administrative processes in each of the districts. Without a centralised funding mechanism, CSOs are expected to navigate complex bureaucratic systems on their own. This discourages some CSOs from even attempting to seek government funding. CSOs would benefit from technical assistance, especially as it concerns navigating complex government systems and improving the quality of proposals.

In some districts, for example, CSOs that wish to access government funding must provide detailed information about specific individuals it seeks to serve. FITRA cited an example of a CSO that struggled to secure funding for basic health services for two transgender community members but were not prepared to respond to the government's request for their full names, occupation, and home address. Such information is collected to stymie corruption.

The political and ideological landscape of a decentralised Indonesia likely precludes a unified advo-cacy strategy. Advocacy campaigns must appeal to local sensibilities, local epidemic features, and adapt to changing political realities. With such diversity across these areas, repeating a given strategy in more than one district is likely to be ineffective. A simple example of this is in Semarang where FITRA found that health expenditure peaks in years that city mayoral elections are held, meaning that budget advocacy would need to follow a specific timeline.

Legal entitlements also determine access to national funding mechanisms. In Semarang, FITRA found that CSOs working in the field of prevention faced non-fulfilment of formal requirements and materi-al of incorporation of legal entities. On average, CSOs in this field lack a notarised deed of establish-ment, which effectively means that they are not legally registered as one of the requirements in any multi-layered grant application stipulates that the proposing institution must be a legally recognised entity. This hinders access to available public local facilities and government funds. FITRA found that stigma is sometimes the reason for a rejected registration application (e.g., if waria, a term for a third gender community in Indonesia, is in the title of the organisation).

Lessons

Other CSOs who wish to perform budgetary analyses can do so—Indonesian law requires the Ministry of Finance and the Ministry of Home Affairs to make budgetary data publicly available. With these data in hand, CSOs could perform the same kind of analysis and data-driven advocacy that IAC and-FITRA have done in Bandung and Semarang. Budget advocacy that is done without prior budget anal-ysis is unlikely to have any impact in FITRA's perspective.

As with any long-term strategy to persuade policymakers, relationships matter. FITRA does not shy away from criticising local governments, but it does so in a constructive manner by proposing solu-tions and compromise. It views every interaction with government officials as an opportunity to build their capacity. Likewise, FITRA offers training opportunities to build the capacity of CSOs to cultivate good working relationships with their local governments.

Using the findings from this analysis, IAC will support local CSOs advocate for increased access to domestic funding. One lesson that can be gleaned from this program is that governments are respon-sive to arguments in which their performance is compared to other districts. This method relies on the so-called social comparison heuristic—a fundamental human disposition for endeavoring to not underperform peers. By presenting budgetary analysis that indicated more harmonious budget allo-cations in nearby districts, IAC and FITRA found that government officials were more motivated to make changes in their own budgets.

The experience of budgetary analysis in Bandung and Semarang illuminated the importance of the exercise but also the futility of entrusting a single actor to take it on given the vastness of Indonesia's geography and sociopolitics. Instead, FITRA and IAC recommend a divide and conquer approach, whereby local actors are capacitated to perform local analyses and develop advocacy strategies that are suitable to their unique environments.
In the future absence of large international donors, civil society in Indonesia will likely be compelled to discover the importance of government budget advocacy. Doing so effectively will require intensifying technical assistance and engaging Global Fund and other donors to support the process. New collaborations, such as those created under the SHIFT Program, are needed to assist HIV CSO and KP networks navigate complex bureaucratic budgeting systems and perform data-driven advocacy. This will be particularly important since the job of raising awareness locally and persuading provincial governments to budget appropriately for HIV interventions will likely remain in the hands of local CSOs.

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