HIV/AIDS Control in West Java: Strengthen the Network of Stakeholders as a Final Solution?

An institutional analysis of collaborations in HIV/AIDS control in three local districts of West Java (Indonesia).

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Preface

This master's thesis is the final proof of competence in obtaining the Master's of Science degree in Public Administration from Radboud University, Nijmegen. I wrote this master's thesis in combination with an internship at Nijmegen International Center for Health Systems Research and Education (NICHE). This internship gave me the opportunity to be closely engaged with global health problems. Due to my great interest in health care systems and my passion for exploring new cultures, I am very grateful that I had the opportunity to travel all the way to Bandung in Indonesia. I attended many meetings and congresses, and I met interesting people who all struggle with the largest and longest lasting epidemic in the world. I became particularly interested in the entire system of HIV/AIDS control, and therefore I decided to dedicate my final work at this university to contributing to this complicated issue.

HIV/AIDS is one of the most challenging global health problems because the virus is still expanding while medical treatment is not accessible for all people. Although the number of new HIV infections is declining globally, this trend is definitely not the case for Indonesia. Collaboration between a wide range of stakeholders is seen as today's final solution to combat the HIV/AIDS epidemic. However, it is clearly visible that some parts of Indonesia have created a stronger network of stakeholders. This qualitative research explains the differences in collaboration between stakeholders facilitated by the Layanan Komprehensif Berkesinambunhan (LKB) program in three districts on West Java. The results provide important insights for the study of governance, shedding new light on the conditions of an effective collaboration network of stakeholders in the Indonesian HIV/AIDS response.

I would like to take the opportunity to express my gratitude to several people. First of all, I am very grateful to the research institute NICHE, which gave me the possibility to do an internship with this master's thesis as final result. Besides improving my research skills extensively, I gained the experience of being strongly involved in a researched project. It is, especially, Noor Tromp that I need to thank, as she helped me to organize my field work in Indonesia. My gratitude goes as well to the staff of Universitas Padjadjaran, who helped and supported me during my time in Bandung. In particular I want to thank Rozar Prawiranegara who brought me into contact with several stakeholders in the field and familiarized me with all the necessary complex institutions and regulations. Furthermore, I need to be very grateful to Febrina Maharani, who joined me for all interviews and defeated the language barriers for me. This research would not be finished without Febrina's assistance, and my experience of living in Indonesia would not have been so great without her. Next, I am indebted to Jan Kees Helderman for his enthusiasm, support and constructive feedback. Finally, I am also grateful to all of the civil servants, experts and others for their participation in this study.

List of abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Live-saving antiretroviral therapy
DAC	District AIDS Commission
DHO	District health office
FSW	Female sex workers
GDP	Gross domestic product
GPA	Global Programme on AIDS
HDI	Human development index
HIV	Human immunodeficiency virus
IAD	Institutional Analysis and Development framework
IDR	Indonesian Rupiah
LKB	Layanan Komprehensif Berkesinambunhan
MoH	Ministry of Health
MSM	Men having sex with men
NAC	National AIDS Commission
NGO	Non-governmental organization
PAC	Provincial AIDS Commission
P.C.	Personal Communication
PHO	Provincial health office
PRISMA	Priority Setting using Multiple Criteria
PWID	People whom inject drugs
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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Chapter 1 – Introduction

1.1 Introduction

In June of 1981, an American scientist reported the first evidence of a new disease: acquired immunodeficiency syndrome (AIDS), caused by the human immunodeficiency virus (HIV). Since the first reported case of AIDS, the virus has spread to all the countries of the world, more than 60 million people have been infected with HIV, and it has claimed more than 35 million lives so far (a. WHO, 2015). All things considered, the HIV/AIDS epidemic has become one of the most important global health challenges (a. UN, 2015). International organizations, such as the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), work constantly on this global health issue in order to achieve the Sustainable Development Goals of the UN: in 2030, the AIDS epidemic must be stopped, and the lives and wellbeing for all infected people of all ages must be ensured (b. UN, 2015). As result of effective interventions, such as HIV testing and medical services and prevention measures, the number of new HIV infections is already declining globally (UNAIDS, 2013, p. 4).

However, not all countries have shown effective measures to deal with the epidemic. Indonesia, for example, is one of the few countries that is not on track to control its HIV epidemic. In fact, Indonesia is definitely a cause for concern since new HIV infections will increase continuously across the entire country (UNAIDS, 2014, pp. 63–64). Together with Bali and the capital city, Jakarta, the province of West Java has one of the fastest growing HIV epidemics in Indonesia (PAC, 2009, p. 5). Unless the government develops an effective answer to this issue, the appearance of HIV/AIDS will increase considerably. Due to Indonesia's decentralized political system, some districts in West Java are more effective in establishing an HIV/AIDS response than other districts. The city of Bogor, for example, offers HIV services in all health clinics, with the result that many people have been tested. Bandung, the capital city of West Java, is on the contrary less effective in responding to HIV/AIDS. Here, HIV services are not offered in all health centers, with the result that many people still do not know their status (West Java Central Bureau of Statistics, 2015; Ristya Rahmani, 2015, pp. 10–11).

Even though the HIV/AIDS control effort has been scaled up considerably, the epidemic is still not under control in Indonesia. It is such a big global health issue that it cannot be handled by the Indonesian government alone. Private actors, civil society and other governments are all essential to organize a multifaceted response, and governance is nowadays used as main method to organize such an effective HIV/AIDS response. Governance refers to steering and decision-making functions carried out by decision makers. These decision makers collaborate with actors from different government layers and sectors (b. WHO, 2015). It seems that the Indonesian government also uses governance in

its HIV/AIDS policy by involving civil society, the private sector and other international development partners. In addition, the decentralized structure has contributed to the establishing of AIDS commissions on the national (National AIDS Commission [NAC]), provincial (Provincial AIDS Commission [PAC]) and local level (District AIDS Commission [DAC]). Lower-level AIDS commissions are allowed to develop their own programs as long as they conform with national policies. This autonomy helps to develop context-specific interventions that are more suitable to local needs. The LKB program (in English: Continuum of Care) is that particular program that helps districts to strengthen the network of stakeholders at local levels. It aims to improve collaboration between government institutions, health care providers, civil society organizations and the public in order to deliver effective HIV/AIDS control (Prawiranegara & Tromp, 2015, pp. 2–8).

1.2 Research problem

Many stakeholders from state, public and civil society need to collaborate in one system, as it has become clear that the government cannot alone handle this enormous problem by itself (Dubé, Addy, Blouin & Drager, 2014, p. 206). However, this whole-of-society (WoS) paradigm does not propose concrete measures to involve all these stakeholders effectively, as it depends highly on the local circumstances. The LKB program is offered to districts to strengthen the network between all stakeholders on the local level, but the implementation of this framework has already encountered some challenges in several districts (Prawiranegara, 2015, p. 1). Not all districts are able to involve stakeholders from outside the health sectors, and not all districts have embraced a unified vision, since the priority of combatting HIV/AIDS is not shared by everyone (Ristya Rahmani, 2015, pp. 10–11). Bandung, for example, has already implemented the LKB framework, although the collaboration structure is still weak. The entire direction of the HIV/AIDS response is determined by the local AIDS commission, with a clear absence of all other relevant stakeholders (DAC Bandung, 2012). Bogor, on the contrary, is one of the cities that implemented the LKB consistently, which has resulted in strong and successful collaboration between several parties (DAC Bogor, 2014).

The extremely high level of need for intensification of the Indonesian HIV/AIDS response, in combination with the existing differences between districts in implementing the LKB program, functioned as the starting point of this thesis. This study attempts to answer the question of why some districts have performed relatively well in implementing the LKB program, while other districts have been less successful. Therefore, it was necessary to conduct an institutional analysis of the setting in which stakeholders collaborate. A comprehensive analysis provides, subsequently, insight into the necessary conditions for successful implementation of the LKB framework in the district of West Java. Besides addressing the above purpose, this research attempts to contribute to the theoretical debate about governance in the health sector.

It intends to answer the following research question:

"What explains the large discrepancies in the implementation of the LKB program in the three districts of West Java concerning collaboration among stakeholders, and what are the subsequent conditions for successful collaboration?"

The following sub-questions guide this research:

1. What is the current status of the HIV/AIDS epidemic and programs in the world, in Indonesia and in West Java?
2. What does the literature propose for governing global health issues, and which theories explain institutional diversity in the LKB program in West Java?
3. What institutional settings of collaborations are present in the three different districts of West Java (Bandung, Cirebon and Bogor)?

1.3 Theoretical focus

This research aims to deliver a comprehensive analysis of collaboration in the HIV/AIDS response in West Java. Therefore, a theoretical section is needed to elaborate on the descriptive and explanatory purposes of this research. This theoretical section starts with a brief introduction to governance, since it is used as the basis of every HIV/AIDS policy on the global, national and local levels. The WoS paradigm fits the idea of governance by proposing the involvement of several sectors all together in one system. Multi-level and multi-sectoral partnerships should be established in order to tackle the HIV/AIDS problem from different perspectives (Dubé et al., 2014). The monitoring and reporting of these collaborations in local HIV/AIDS responses is done based on the institutional analysis and development (IAD) framework of Elinor Ostrom (2005; 2011). The IAD framework assigns all relevant explanatory factors to categories and locates these variables within a foundational structure of logical relationships (McGinnes, 2011, p. 169). The rigorous character of the framework makes it appropriate for understanding why some districts perform relatively well in working together, while other districts have been less successful. Subsequently, a cross-sectional analysis of the three institutional settings helps one to "learn from differences" and to discover the conditions for successful implementation of the LKB program.

1.4 Methodology

A qualitative multiple-case research design was followed in this study. Bandung, Bogor and Cirebon were selected as the three most similar cases, with a comparable contextual setting but with dissimilar outcomes for previous HIV/AIDS programs and a different cooperation style. Institutional analysis was employed, grounded in all three cases on the theoretical framework of Elinor Ostrom (2005; 2011). To answer the research question, interviews were conducted with various relevant stakeholders and other qualitative data was gathered in the form of observations and documentation. The interview

transcripts were coded employing both inductive and deductive coding strategies. The deductive codes were derived from the existing literature, whereas the inductive codes were developed from examining contextual factors (Miles & Huberman, 1994). By choosing representative cases and by using more data collection methods, it was possible to retrieve useful information on the involved actors and their collaboration in the local HIV/AIDS response.

1.5 Societal relevance

This research has great social value. It is, first of all, useful for the policy makers who implement the LKB program in West Java. The outcomes of this research provide knowledge about best practices regarding the implementation of this program. Policy makers can use the outcomes to improve the collaboration systems in order to succeed with the future programs. As a result of a better system, the citizens of Indonesia benefit too. The HIV/AIDS epidemic in Indonesia is one of the fastest growing in Asia, and if the government does not take effective action, HIV infection will spread enormously (NAC, 2009, pp. 15–16). This research will help to improve HIV/AIDS programs in Indonesia, hopefully resulting in a reduction or even stop of the epidemic.

1.6 Academic relevance

Besides its societal relevance, this research is highly relevant from a public administration view. Governance is nowadays a frequently used concept, adapted to almost all HIV/AIDS strategy plans. The WoS paradigm is the subsequently proposed method in order to involve a wide range of stakeholders. However, the exact use of the concept is still vague, as the dynamic of WoS paradigm depends much on local conditions. Therefore, the theoretical insights that result from this thesis might prove to be a valuable contribution to the WoS paradigm. As well, this research provides a better understanding of institutional diversity within a specific context. This study looks closely at both the external and the internal variables that influence the institutional setting. This more comprehensive and in-depth research contributes to existing knowledge about HIV/AIDS programs in the different districts. By combining Ostroms' framework with the WoS paradigm, I hope to contribute to the theoretical foundation behind the solution of global health issues.

1.7 Thesis outline

This thesis proceeds with a policy outline in Chapter 2, providing an introduction to the HIV/AIDS epidemic and policies in the world, Indonesia and West Java. Chapter 3 discusses the state of art in the academic literature about governance, the WoS paradigm and institutional diversity. This discussion helps to create the theoretical framework that will be used in order to study the variance between the LKB programs in the districts. In Chapter 4 the research design of this thesis is presented together with the data collection, data analysis, and the operationalization. Chapter 5 describes the context's external variables that influence the collaborative setting in the districts. Chapter 6 presents the main results of

this thesis. First, it is set out how stakeholders in the districts collaborate in the HIV/AIDS response and, subsequently, the results are cross-sectionally analyzed to infer the conditions of successful collaboration. Finally, Chapter 7 concludes the thesis with the answer to the research question and the main implications and contributions of this study.

Chapter 2 – HIV/AIDS as a global health problem

2.1 Introduction

HIV/AIDS has for many years been one of the most critical and challenging infectious diseases that has expanded to every country in the world. There is a general agreement nowadays that something should be done to stop new infections and to reduce the impact of HIV/AIDS on people's well-being and their environment. However, despite the shared awareness of the need to invent these policies, it seems to be hard to accomplish this task. The total number of people living with HIV/AIDS is still increasing in the world, while medical treatments are not universally accessible for everyone (a. UN, 2015). This chapter begins with an introduction to this global health problem in Section 2.2, aiming to understand why it is such an exceptional issue. A more extensive elaboration of the HIV problem in Indonesia and more specifically in West Java is provided in Section 2.3 and Section 2.4. Afterward, Section 2.5 elaborates on the LKB program that fits today's trend of governance. Chapter 2 concludes in Section 2.6.

2.2 HIV/AIDS: A problem for the entire world

HIV/AIDS is one of the hardest challenges of today's world (a. UN, 2015). It remains unclear, however, how disastrous the HIV virus actually is. This section provides insight into the exceptionality of the virus and the way that international organizations try to deal with it.

2.2.1 The exceptionality of HIV/AIDS

In 1981, HIV was identified as the cause of AIDS. HIV effects the immune system with the consequence that infected people are more susceptible to common infections than people with healthy immune systems. HIV is primarily transferred by unprotected sex, blood transfusions, infected needles and from mother to child during pregnancy (Lisk, 2010, p. 10). In HIV/AIDS' early stages, medics assumed that this disease occurred only in rich western countries. However, some other doctors immediately recognized similar conditions among patients in central and western African countries. As a result of the quick and easy spread of the HIV virus, AIDS has been identified and reported in every country in the world (Lisk, 2010, p. 2). According to statistics published by UNAIDS in 2016, 36.7 million people live with HIV around the world, an estimated 35 million lives have been lost due to AIDS, and more than 2.1 million people have been diagnosed with HIV in 2016 (a. UNAIDS, 2016). Besides the impact on human well-being, HIV strongly effects the economic and social development of individual people and entire countries. Consequently, HIV has become one of the most challenging global health issue.

Although the world has faced other global epidemics, the HIV/AIDS epidemic is exceptional. First of all, the specific biomedical characteristics of the disease make the transmission of the virus relatively fast. Secondly, there is still no known vaccine against HIV, while the numbers of new infections is still increasing dramatically in some parts of the world. This second consideration brings us to the third reason this epidemic is exceptional: Even after three decades, the epidemic has not been stopped (Figure 1). Therefore, the HIV/AIDS epidemic is considered as one of the longest-lasting epidemics. Fourth, the impact of AIDS on individuals and societies has been complex because legal and ethical issues are linked to the problem. For example, people suffering from the disease have to deal with stigmatization and discrimination, and communities still do not always want interventions that contradict their cultural values. Lastly, compared to its role in other global health problems, human behavior has a strong influence on the epidemic's persistence. Since there is no vaccine to protect against HIV, individuals should take responsibility not to put themselves at risk of infection (Lisk, 2010, pp. 2–4).

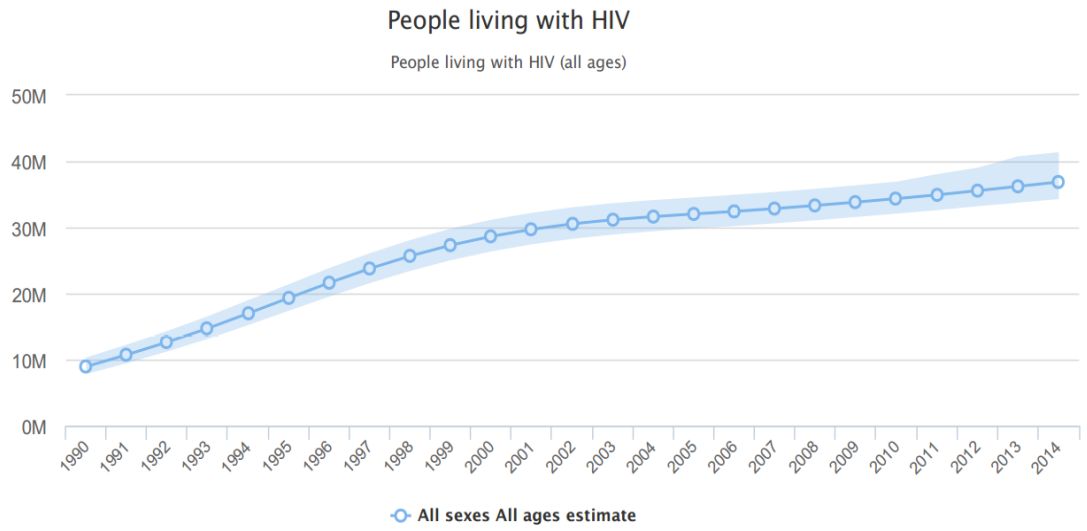

Figure1: The total number of people living with HIV around the world (b. UNAIDS, 2016).

2.2.2 Global answer to HIV/AIDS

Despite the exceptional qualities of this global health issue, there is still hope for the end of the HIV/AIDS epidemic. Several international organizations work on this issue in order to achieve the Sustainable Development Goals of the UN: In 2030 the AIDS epidemic must be stopped and the lives and wellbeing of all infected people of all ages must be ensured (b. UN, 2015). Therefore, the HIV/AIDS problem is a substantial topic on the international agenda that has resulted in one of the largest health programs focused on a single disease (Lisk, 2010, p. 7). The start of this global response was, however, rather slow due to the denial of HIV's prevalence at the time of its discovery. Eventually, the WHO had to recognize HIV/AIDS as a global health problem after an enormous increase of new infections. In 1987, the Global Programme on AIDS (GPA) was established, which

can be seen as the beginning of the awareness of a worldwide global health crisis (Lisk, 2010, pp. 16–17). However, it soon became clear that the WHO is not capable of controlling the HIV epidemic by themselves. The WHO is a health organization, while the HIV/AIDS problem also needs to be addressed by institutions outside the health sector. Consequently, UNAIDS was introduced in 1996, which is nowadays the main advocator for coordinated global action. Another crucial international stakeholder is known as Global Fund (GF). GF is a partnership organization founded in 2002 to accelerate the stop of AIDS, tuberculosis and malaria as infectious diseases in the world. It is a financial institution supported by both governments, private companies, other beneficial experts and directly affected people (The GlobalFund, 2016).

With international help, the stop of the epidemic is not unrealistic. First of all, the number of newly infected people in most parts of the world is declining. There were 2.1 million new HIV infections in 2013, whereas in 2001 3.4 million new infections were reported. It is expected that this decline will continue into the future. Furthermore, as result of the life-saving antiretroviral therapy (ART) fewer people die of AIDS-related illnesses. Due to the increased fund raising, the percentage of people who do not receive medical examination has been reduced from 90% in 2006 to 63% in 2013 (NAC, 2014, p. 18). Almost half of all people living with HIV are aware of their disease, and that helps people to start their medical treatments (UNAIDS, 2014, pp. 8–14). Nevertheless, if we want to stop this epidemic, much work still needs to be done. Several regions and countries are responsible for 75% of all people living with HIV. In these parts of the world, HIV infections still increase dramatically. Furthermore, three of five people with AIDS do not have access to the live-saving therapy. And although the total number of new infections is declining, this trend is not the case for the so called key populations; young women and adolescent girls, gay men, prisoners and drugs users are more likely to be living with AIDS than anyone else in the general population (NAC, 2014, p. 18).

2.3 The HIV/AIDS problem in Indonesia

Although new HIV infections are declining at the global level, this decline is not the case for all the countries in the world. Indonesia is one of these countries that has an upward trend rather than the downward trends present in most Asian countries. This section elaborates on the epidemical situation in Indonesia, the background of Indonesia's HIV responses and some reasons that Indonesia, especially, faces challenges in responding.

2.3.1 HIV/AIDS in Indonesia

Since 1987, when the first case of HIV was reported in Bali, the number of new infections in Indonesia has continued to increase. Indonesia's epidemic is one of the fastest growing in Asia (Evidence to Action, 2015, p. 2). According to UNAIDS, between 2005 and 2013 the annual numbers of new HIV infections in Indonesia more than doubled. Nowadays, 660,000 people live with HIV, and

in 2014 alone, 69,000 new infections were reported (UNAIDS, 2014, p. 354). The expectation is that these numbers will increase considerably, unless the government develops an effective response (NAC, 2014, p. 23). Figure 2 shows the past, current and expected growth of new annual infections between 2000 and 2030.

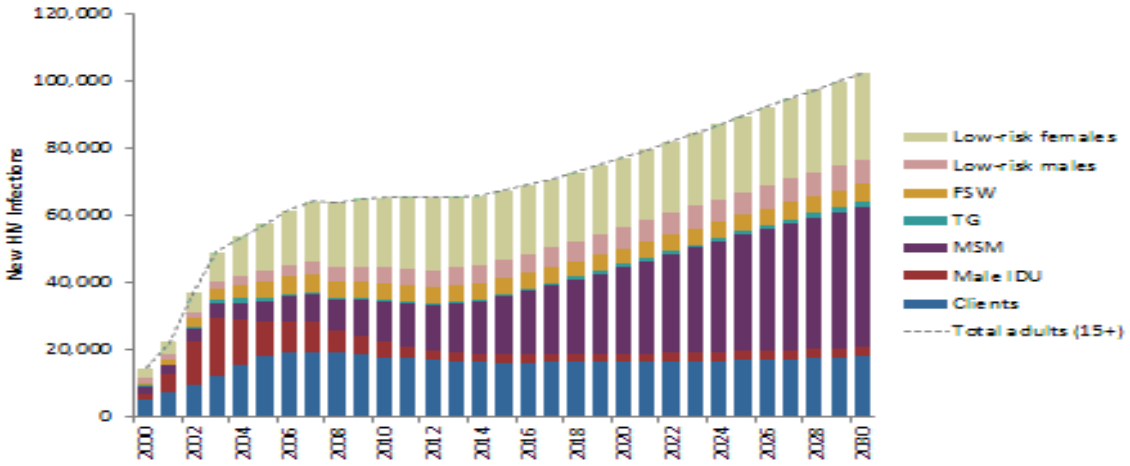

Figure 2: The numbers of annual new HIV infections in Indonesia between 2000 and 2030 (NAC, 2014, p.23). .

As can be seen in the figure above, there is a clear evidence that key populations are overrepresented among the total infected people. HIV prevalence is estimate to be especially high among female sex workers (7%), men having sex with men (8.5%), and people who inject drugs (36.4%) (Prawiranegara & Tromp, 2015, p. 2). The numbers of infected people are the highest in Jakarta and in the highly populated provinces Java and Papua (Figure 3).

Figure 3: HIV prevalence in Indonesia in 2011 (NAC, 2014, p.21).

2.3.2 A brief background of the Indonesian HIV/AIDS response

The Indonesian response was slow after the first reported case on Bali in 1987. HIV has for many years been considered a normal health problem, but after a rapid increase of new infections, a more extensive response was unavoidable (Heywood, 2013, p. 5). In 1987, the Ministry of Health (MoH) established the NAC. Consequently, it became possible to create more specific policies, such as the promotion of 100% condom use in brothels and other sex establishments (1992), screening of blood donors for HIV commenced (1992) and some surveillance teams were formed to provide information (1994) (Heywood, 2013, pp. 18–19). However, the concern about HIV/AIDS increased both in Indonesia and internationally over the time. Since the early 1990s, a consensus emerged that HIV/AIDS has the potential to overwhelm the world. After the national government signed the "Declaration of Commitment on AIDS" from the UN, the Indonesian government really needed to undertake action. A consultation was led by the NAC with the six most effected provinces and ministers from six governments in order to intensify the HIV/AIDS control response. Nevertheless, because of the lack of resources and administrative structure, the results were limited (Heywood, 2013, p. 22).

Partly because of this limitation, the HIV/AIDS response was fully decentralized in 2001 in line with the general political system in Indonesia. As such, provincial and local governments are also responsible for establishing an answer to this fast-growing problem. All government levels must create a strategy plan for at least four years, in which the national strategy plan should function as a guideline. The current national HIV/AIDS strategy (2015–2019) is mainly focused on prevention, care, support and treatment services. Figure 4 presents the four main components of the contemporary national approach to HIV/AIDS.

Figure 4: Four main components of the National HIV/AIDS Strategy 2015-2019

- *'Effective HIV prevention, including treatment as prevention, for key populations and their partners, and improve program effectiveness;*
- *Quality treatment, care and support services that are accessible, affordable and client-friendly for all people living with HIV who need services;*
- *Access to mitigation of the impact of the epidemic, including economic and social support for PLHIV, children and affected families who are living in hardship;*
- *Create an enabling environment that promotes an effective response to HIV and AIDS at all levels, empowers civil society to have a meaningful role and reduces stigma and discrimination' (NAC,2014, p.9).*

2.3.3 Challenges in the Indonesian HIV/AIDS response

Although the Indonesian government has been working on this issue since 1987, this work has not resulted in a decline in new infections. The question arises of how it is possible that Indonesia still cannot control its epidemic, while other countries have been more successful (UNAIDS, 2014, p. 354).

Several reasons can be given for this comparative lack of effective control. Firstly, Indonesia is the largest archipelagic country in the world, with a population of over 220 million. All these people have their own cultural backgrounds, which makes communication and resource distribution more difficult. Secondly, almost all people in Indonesia follow the Islamic religion, and there are associated challenges with convincing authorities to adopt policies that contradict their religion. One example has to do with the distribution of condoms. It is generally known that the use of condoms reduces the risk of getting HIV. However, since Islam forbids sex before marriage, it is hard for unmarried people to get condoms, with the result that they put themselves at risk of infection (Damink, 2016, p. 8). Thirdly, as a consequence of religion, widespread stigma and discrimination still persists. People are, therefore, reticent to enter the HIV facilities. Fourthly, Indonesia uses a punitive approach towards drugs use and prostitution, which limits access to the necessary medical resources for drugs users and sexual workers. Fifthly, many people in Indonesia still do not have enough knowledge about HIV/AIDS. Lastly, a limited number of resources is available to provide the necessary care. Indonesian governments themselves organize only limited funding, which makes them dependent on foreign donors such as international organizations (Evidence to Action, 2011, p. 11). Although there has been an increase in domestic funding for the AIDS response, external funding still counts for more than 50% of the total budget (NAC, 2009, p. 22). All together, these factors make the HIV/AIDS epidemic in Indonesia an even more exceptional and important health issue.

2.4 The HIV/AIDS problem in West Java

Together with Bali and the capital city Jakarta, West Java is one of the provinces with the highest prevalence of HIV. This section starts with a contextual introduction to West Java to create a better understanding of this province. Thereafter, it provides the current status of the HIV/AIDS epidemic in West Java, and it elaborates on the provincial HIV/AIDS response and related outcomes.

2.4.1 Contextual description: A better understanding of West Java

West Java, circled in Figure 3, is considered as the most densely populated Indonesian province, with over 46.3 million residents. This province is divided into 27 districts that all have the autonomy to establish regulations and policies. The GDP per capita is 30.1 million IDR, and the Human Development Index (HDI) is 68.80, which makes this province an average economic performer (GBG Indonesia, 2016; Badan Pusat Statistik, 2015). The total amount of the HIV/AIDS budget is estimated to be 500 million IDR. In recent years, the province has scaled-up HIV services in health care centers. However, it is clearly visible that far from all health services in West Java provide HIV/AIDS care. The percentage of health services providing HIV/AIDS care is around 40% (Damink, 2016, p. 7). Having a closer look at the cultural setting of West Java, it is clear that almost all citizens identify as Islamic. As already mentioned, several experts think that this might be one of the reasons why West Java still does not have control of its epidemic. Some governors believe that this religion’s doctrines

should become law, and that might create problems in the programs' implementation. The distribution of condoms, for example, is rejected by governors, as it promotes free sex. However, international organizations, such as UNAIDS, attempt to dispel this way of thinking because it obstructs the implementation of effective programs. The appendices includes an article about the HIV/AIDS response on West Java and Bali (Damink, 2016). This provides further detail on the contextual setting of West Java, as it provides a comprehensive comparison of two Indonesian provinces.

2.4.2 The HIV/AIDS epidemic in West Java and their districts

West Java has one of the fastest growing HIV epidemics in Indonesia: whereas in 2006 the estimation was that about 23,000 people had been infected, there will be approximately 260,000 people living with HIV in 2020 (PAC West Java, 2009, p. 5). Thus, the epidemiological situation on West Java is worrisome. The table below gives an overview of the HIV epidemic in West Java, specified to the 11 districts that implemented the LKB program. The other sixteen districts in West Java are far behind in responding and consequently are not able to provide useful data. Especially the district of Bandung and the city of Cirebon have high numbers of HIV cases, according to 2014 data. Although the expectation of governors was that the highest proportion of cases comes from transmission through infected needles and from sexual intercourse with sex workers, low-risk woman are primarily the victims of the virus (PAC West Java, 2009, p. 5).

Overview of districts in West Java that have implemented the LKB program

District	Geographical size in km²	Population density per km²	HIV cases per 10.000 people	Type of epidemic based on the three highest representative key populations
Bandung city	168.23	14235.7	33.6	Low risk women, clients of FWS, low risk men
Bandung district	1756.65	1809.4	9.8	Low risk women, clients of FSW, MSM
Bekasi city	213.58	10932.1	14.9	Drugs users, low risk men, low risk women
Bekasi district	1269.51	2072.0	7.3	Low risk women, MSM, clients of FWS
Depok	199.44	8717.3	20.4	Low risk women, clients of FWS, low risk men
Bogor city	111.73	8505.6	27.5	Low risk women, MSM, clients of FSW
Cirebon city	40.16	7380.2	50.2	Low risk women, clients of FWS, low risk men
Cirebon district	1071.05	1930.1	18.7	Low risk women, clients of FWS, low risk men
Tasikmalaya city	184.38	3446.5	14.6	Low risk women, low risk men, MSM
Tasikmalaya district	2702.85	620	9.6	Low risk women, MSM, clients of FWS
Indramayu district	2092.1	795.2	22.4	Low risk women, clients of FSW, low risk men
FSW (Female sex worker) MSM (Men sex with men)				

Table 1: An overview of the actual HIV situation in the districts that have implemented the LKB program (West Java Central Bureau of Statistics, 2015).

2.4.3 Provincial HIV/AIDS responses

The province of West Java, headed by the PAC, has also established a strategy plan that should be used as guideline for districts. However, the latest strategy plan was created for the time period 2010–2013. The PAC has not formulated a new strategy plan yet, and therefore local governments still follow these outdated guidelines. The provincial action plan was developed through an extensive process, with the involvement of various stakeholders. HIV/AIDS has finally become an important

point on the agenda of the Province of West Java. It took several years for the government to give this issue high priority, but nowadays there is general agreement about its necessity. The ultimate goal of the province is to reduce the number of new infections and to reduce the risk of transmission in the community. The characteristics of the current epidemic require primarily preventive interventions in the key populations. Changes in behavior are needed to stop people from having risky sex and using drugs (PAC West Java, 2009, pp. 1–4). In line with the national plan, this action plan consists four components: prevention, care, support and treatment, mitigating the impact of HIV/AIDS, and management and policy development for HIV/AIDS. These four main components are formulated to achieve the common worldwide goal of stopping the emergence of new cases and to improving the quality life of people living with HIV/AIDS. The vison, mission and objectives are summarized in Figure 5.

Figure 5: Vision, mission and objectives of the Provincial HIV/AIDS Strategy 2010-2013

'Vision: A healthy live for the community of West Java to avoid HIV/AIDS.
Mission:

1. *Increase public awareness of the risk of HIV transmission in order to form safer behavior to avoid HIV.*
2. *Provide support to people living with HIV/AIDS*
3. *Develop policies that prevent people from HIV/AIDS*

Objectives:

1. *Strengthening implementation of the cooperation network KPA provincial, districts, NGOs and other community elements to reach populations at risk with effective behavior change intervention for the entire region of West Java.*
2. *Implemented a comprehensive medical service network of all regional hospitals and health centers and private to private clinics for the community and people living with HIV.*
3. *Issuance of regulations by the provincial government and district government for the implementation of HIV and AIDS prevention program is comprehensive and effective'(PAC West Java, 2009, p.10).*

2.4.4 Outcomes of the HIV/AIDS responses in West Java

This section will have a closer look at outcomes that have been achieved as result of actions. The available data makes it possible to elaborate on the following outcomes: HIV cases per 10,000 people, the number of primary health care centers with HIV services and the number of people that receive their testing results. The LKB program was implemented with the purpose to strengthen the collaboration between several stakeholders (Prawiranegara & Tromp, 2015, p. 8). The current status of the collaboration can be researched based on previous research of the PRISMA research team. The two dimensions that help to determine the success level of a collaboration are as follows: unified vision and trust among stakeholders (Ristya Rahmani, 2015, pp. 10–11). All outcomes for the districts in West Java are summarized in the table below.

Overview of outcomes in the districts of West Java

District	HIV cases per 10.000 people	Number of primary health care with HIV services per total number of primary health care available	Number of people that received their testing results in percentage of the total population	Unified vision	Level of trust among stakeholders
Bandung city	33.6	24 / 73 (32.9%)	19.737 (0.8%)	Low	Low
Bandung district	9.8	9 / 62 (14.5%)	3.175 (0.1%)	Low	Low
Bekasi city	14.9	17 / 31 (54.8%)	21.115 (0.9%)	Low	Low
Bekasi district	7.3	7 / 39 (17.9%)	4.710 (0.2%)	High	Very high
Depok	20.4	9 / 32 (28.1%)	952 (0.05%)	High	High
Bogor city	27.5	24 / 24 (100%)	23.562 (2.5%)	Very high	Very high
Cirebon city	50.2	5 / 22 (22.7%)	8.881 (3%)	High	High
Cirebon district	18.7	15 / 57 (26.3%)	24.285 (1.2%)	Middle	Neutral
Tasikmalaya city	14.6	19 / 20 (95%)	15.841 (2.5%)	High	High
Tasikmalaya district	9.6	5 / 40 (12.5%)	12.908 (0.08%)	High	Very high
Indramayu district	22.4	11 / 49 (22.4%)	9.562 (0.6%)	Low	Low

Table 2: An overview of the outcomes of HIV/AIDS programs in the districts of West Java (West Java Central Bureau of Statistics, 2015; Ristya Rahmani, 2015, pp. 10-18).

The outcomes in these 11 districts of West Java are diverse. Not only are the quantitative outcomes varied, but the districts differ also between levels of unified vision and levels of trust among stakeholders. Some districts are clearly more effective than other districts; Bogor, for example, has established full coverage of HIV services in all health centers. All patients that visit a health clinic can be tested for HIV. This level of coverage results in a relatively high number of people who also received their testing results. Furthermore, the table above implies that a high number of HIV cases is related to a high number of people who got tested. The city of Cirebon, for example, has the highest number of recorded HIV cases in West Java, but at the same time also the highest number of people who received their testing results. Cirebon is successful in discovering HIV cases, with the result that people with the diagnoses can start treatments. Bandung, on contrary, scores relatively weak on all outcomes. According to previous research, Bandung has a weak collaboration model for stakeholders, which might result in a low percentage of both HIV services and people who got tested. However, it is too early to draw such conclusions. Still, compared to Bali, the outcomes in West Java are not as good as they must be (Damink, 2016, pp. 6–9). Not all health centers are able to deal with HIV, and too few people get tested. Nevertheless, some districts in West Java are already better equipped to deal with HIV/AIDS than other districts.

2.5 The LKB program: A key to effective collaboration

Nowadays, almost all global health organizations use governance as their main tool to organize intervention programs effectively. Governance in the health sector refers to steering and decision-making functions carried out by decision makers. These decision makers collaborate with actors from different government layers and sectors (b. WHO, 2015). Although the next chapter discuss

governance from a theoretical perspective, this section will introduce the LKB program, which can be seen as a program to implement successful collaboration among this wide range of stakeholders.

2.5.1 Governance in the Indonesian response

It is also the Indonesian government that attempts to implement governance theories in their response. According to the MoH, partnerships between different stakeholders should be the hallmark of the entire response. Initially, the MoH followed the recommendations "to form an inter-sectoral body to lead the government response with some emphasis on cooperation and collaboration between the various economic and social sectors and non-government organizations" (Heywood, 2013, p. 19). Due to the decentralization, districts have some discretionary policy freedom to interpret the nationally and provincially established policies and strategies. So, although districts have autonomy to work by themselves, they still have to follow the general policies created by higher levels, which creates a vertical relationship between different government layers. In addition to cooperation between government layers, it is important to involve civil society, the private sector and other international non-governmental organizations (NGOs) at all levels of government (NAC, 2014, p. 30). Since HIV is a problem that goes beyond the health sector, several ministries and NGOs are also involved, working on a horizontal level. Figure 6 provides an ideal overview of the involved stakeholders in the Indonesian HIV/AIDS response. However, as mentioned in the previous sections, this structure is not applicable to all districts in West Java. Chapter 6 examines further the involvement of stakeholders in three West Javanese districts, and therefore the figure below should be used for only a general understanding. An overview of the main tasks of the stakeholders is added to the appendices.

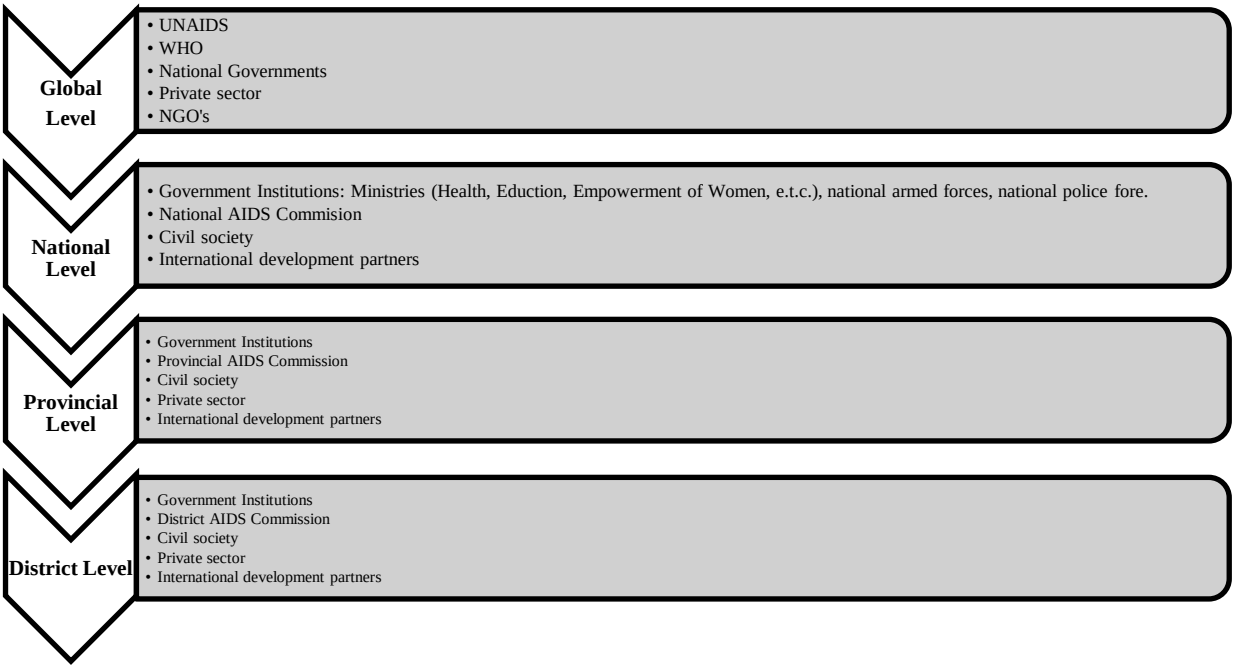

Figure 6: An overview of the ideal involvement of stakeholders and the governance structures within the Indonesian HIV response.

2.5.2 The LKB Program

The LKB program is that particular program that must strengthen the network of government institutions, health care providers, civil society organizations and the public in order to deliver effective HIV/AIDS services (Prawiranegara & Tromp, 2015, p. 8). Since the national strategy 2015–2019 adjusted the ongoing decentralization of powers and responsibilities to lower-level stakeholders, the LKB has been introduced as the framework and platform for implementation of initiatives at the local level (NAC, 2014, p. 39). All these collaborating organizations should work together on coordinated care, treatment and support services for HIV. The LKB should link different services provided in homes, communities and institutions to make it easier for people to enter the health services (Green, McPherson, Fujita, et al., 2007, p. 8). Currently, the LKB program is rolled out in every district of West Java. An official evaluation has never been made of this particular program by the inventors or by externally involved parties. However, based on experience, stories and other informal meetings, the general understanding is that the LKB implementation encounters some challenges (Prawiranegara, 2015, p. 1). The described outcomes endorse the problems of creating the network of stakeholders. Several districts are not able to create an unified vision and trust among each other (Ristya Rahmani, 2015, pp. 17–18). Therefore, it is useful to do more in-depth research to investigate the essential elements of good collaboration, as it is expected that such collaboration contributes substantially to the HIV/AIDS response.

2.6 Conclusion

This chapter makes clear that the HIV/AIDS epidemic is an enormous problem for the entire world. Although most parts of the world have seen a decrease of new infections, this trend is not the case for Indonesia. It is, especially, the province West Java that has an extremely high prevalence of HIV. Unless the government establishes effective HIV/AIDS control, the HIV virus will spread continually in this province (PAC West Java, 2009, p. 5). Nowadays, governance is used as main point the implementation of HIV/AIDS action plans more efficiently. Today's HIV response program in West Java is, therefore, much more complex than it was in when it began of the 1990s. A shift has been realized, from a response based solely on the Ministry of Health to one that now has a central role also for many public, private and civil society organizations (Heywood, 2013, pp. 19–23). The LKB framework aims to strengthen the network between the wide range of involved stakeholders at the local level. However, this chapter made it clear that West Java definitely has a problem organizing an effective HIV/AIDS response. The number of infections is still increasing dramatically, while health services and the number of people who get tested is still low. Nevertheless, the outcomes in the districts of West Java are not all disappointing. Several districts perform significantly better than other districts. Therefore, a comparison between districts can help to explain the discrepancy. The next chapter will provide theoretical insight that might help to explain the institutional diversity and to discover the conditions of successful collaboration.

Chapter 3 – Governing the HIV/AIDS control

3.1 Introduction

As the previous chapter has shown, the HIV/AIDS epidemic is an enormous collective problem that is challenging to govern. One of the reasons for its difficulty is the wide range of involved stakeholders. Since the HIV virus has appeared globally, it is hard for any single government to respond alone. The global nature of the problem makes it, therefore, necessary to involve international organizations. In addition, the implementation of the response requires stakeholders from all kinds of perspectives. Private actors, civil society and governments are all essential in the organization of Indonesia's response. It seems to be an impossible task to organize the response with all these different actors. However, governance is considered the solution to this collective action problem. Governance encompasses the collective actions and collective solutions that are needed to pursuit common goals created by both formal and informal stakeholders (Dodgson, Lee & Drager, 2002, p. 5).

This chapter starts in Section 3.2 with a description of the term "governance" and the subsequent terms "multi-level governance" and "global health governance" (GHG). The essential elements of GHG (Section 3.2.3) and the two causes of a panacea problem (Section 3.3) contribute to the development of the WoS paradigm. This paradigm is nowadays frequently used by the WHO and UNAIDS, which makes its further explanation in Section 3.4 valuable. The IAD framework functions as starting point to understand institutional diversity and therefore, all essential parts of this framework are described in Section 3.6. Experimentalist governance, explained in Section 3.7, is a suitable approach to learn from the differences between districts. I close this chapter in Section 3.8 with the theoretical framework that guides the answer of the research question.

3.2 Governance

The term governance has become very popular over the past several decades. It is a frequently used concept that is central to all different kinds of studies. However, since the origins, meanings, significance, and implications of the concept of governance are often disputed, there is no clear definition of this concept (Levi-Faur, 2014, p. 3). Nevertheless, in this study the term governance is frequently deployed, and therefore it is still useful to parse the concept.

3.2.1 Back to the basics of governance

Many issues require collective action within societies, since it has become clear they cannot be addressed adequately by individuals. Often, a wide range of stakeholders must start collective action and deliver collective solutions to pursue common goals. Institutions and regulations are becoming increasingly pluralistic. "Besides the traditional government structures, international organizations,

civil society, public-private partnerships, and other non-state entities, decision-making processes for building institutions and creating policies appear" (Búrca, Keohane & Sabel, 2014, p. 1). Governance can be seen as a network process that helps to understand these complex relations between multiple actors. Whereas *government* covers activities based on formal authority, *governance* refers to activities supported by both formal and informal actors (Dodgson, Lee & Drager, 2002, p. 5). According to Levi-Faur, governance has at least four meanings in public administration literature: a structure, a process, a mechanism or a strategy: "As a structure, governance signifies the architecture of formal and informal institutions; as a process it signifies the dynamics and steering functions involved in the lengthy never-ending processes of policy-making; as a mechanism it signifies institutional procedures of decision-making, of compliance and of control (or instruments); finally, as a strategy it signifies the actors' efforts to govern and manipulate the design of institutions and mechanisms in order to shape choice and preferences" (Levi-Faur, 2014, p. 8). Each of these facets are applicable to the Indonesian HIV/AIDS response.

3.2.2 Shift to multi-level governance

Many different kinds of governance theories have been developed by scholars over the years. One of these types, which is useful to this research, is known as multi-level governance. Multi-level governance is based on the idea of pluralism and policy network. It seeks to capture complex relationships, across government levels, that emerge when stakeholders from several parts of government share the tasks of making regulations and forming policy (Hague & Harrop, 2010, p. 271). The basic idea is that all levels of government should start working on their horizontal and vertical relationships. Vertical relationships include actors of different government tiers within the same policy field, whereas the horizontal relationships involve discussion with people at the same government level but working in different policy areas. Consequently, government institutions from a range of sectors and from different layers are involved to establish policies together.

3.2.3 Global health governance (GHG)

GHG is that type of governance which is particularly focused on the health sector. Whereas multi-level governance includes cooperation within authorities, GHG incorporates also non-authorized organizations. The term GHG is now widely used and clearly adopted by organizations such as the WHO and UNAIDS (Lee & Kamradt-Scott, 2014, p. 1). It concerns "the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population" (Dodgson, Lee & Drager, 2002, p. 6). GHG is umbrella concept that involves a range of governing activities and mechanism used by various public and private actors, acting at international, national and local levels (Kay & Williams, 2009, pp. 1–2).

Dodgson, Lee and Drager (2002) have formulated some essential elements of GHG that help to demonstrate the visibility of the concept in Indonesian HIV/AIDS control. The first element is focused on the deterritorialization. There is a need to address health problems without the geographical boundaries of a state. Due to globalization, an intensification of cross-border and trans-border flows of people, goods and services has emerged. The HIV virus has expanded to every country, which makes it unavoidable for a country to neglect this global health issue (a. UN, 2015). Infections like HIV cross national borders, and therefore, it is necessary to work on a larger scale than the national. Furthermore, as a result of globalization, the possibilities of exchanging knowledge and information are much better than in previous years. Global cooperation can help to generate better results, since more countries can give input.

The second element is based on the multi-sectoral approach. GHG needs to define and address health problems from a multi-sectoral perspective. Although biomedical studies are dominant in the health sector, it has become clear that other policy sectors can also be useful in effective health care response. Therefore, it is important to increase the involvement of other forms of expertise in the creation of health policy. The education sector, for example, is crucial to implement HIV prevention programs to school kids. Furthermore, the involvement of the private sector is required, as result of a shrinking of resources. In 2013, the HIV/AIDS response had to deal with a shortage of 23 million USD, and this resource gap is expected to further expand. Foreign international donors subsidize at least half of the entire response, but this subsidization will likely decrease. Therefore, the Indonesian government should find alternatives to increase resource allocation in the private sector (Tromp, 2015, p. 6).

The third element of GHG is based on the multi-level approach. There is a need to involve more government levels, as a centralized government cannot solve this problem by itself. Greater collaboration among government actors is necessary because of the growing demands of their populations (Lee & Kamradt-Scott, 2014, p. 3). Due to the expansive cultural diversity of Indonesia, local communities are getting more involved with political issues. Furthermore, problems like HIV/AIDS are close to the lives of people themselves, which makes response on a local scale more likely . However, the priority given by local authorities is still not high enough, and therefore central control is mandatory. The combination of autonomy and central control needs to be well organized into a multi-level collaboration.

3.3 HIV/AIDS as a panacea problem

Even though the HIV/AIDS control effort has been scaled up considerably by involving all these different actors, it is still not moving towards its goal. Current data collection has shown an increase of new HIV infections in Indonesia, in contrast to a decline of new infections in other Southeast Asian countries. Many solutions and action plans have been established on the global scale by organizations

such as the WHO, UNAIDS and GF. Although these efforts have resulted in a downward trend of new infections in some countries, this trend is not present for Indonesia. Therefore, HIV/AIDS can be considered as a "panacea problem": A kind of problem that occurs whenever a single presumed solution is applied to a wide range of problems (Ostrom & Cox, 2010, p. 2).

There are two dimensions that cause panacea problems. The first dimension occurs when a theory is too precisely formulated to be flexibly adapted to the requisite range of contextual situations. Many scholars have agreed with the fact that it is necessary to create policies that fit the actual context in which policies have to be implemented. A government may fail to create effective policy by homogenizing the contexts of different target groups. This homogenous approach is known as the blueprint approach, which leads to a lack of fit between programs and their supposed social-ecological targets. In order to avoid this problem of homogenization, it is necessary to establish policies that are suitable for local conditions. The second dimension of panacea problems can be seen as the opposite of the first dimension. A panacea problem occurs when theories are extremely vague instead of extremely precise. When a very general and broad policy idea is set up on a large scale, implementers on a lower scale do not know precisely what they have to do. Therefore, control is also needed in order to direct action at a lower level (Ostrom & Cox, 2010, p. 2).

3.4 WoS paradigm: A new governance paradigm

Governance was expected to be an effective method to organize the response of all of the different stakeholders. The WHO and UNAIDS promote governance strongly, but the involvement of stakeholders does not proceed smoothly in all districts of West Java (Ristya Rahmani, 2015, pp. 10–11). Based on the two causal dimensions of a panacea problem and the three elements of GHG, a governance approach have evolved known as the whole-of-government (WoG) paradigm. This approach intends "to explore concrete ways to reduce fragmentation and increase integration, coordination and capacity to work effectively across boundaries of organizations, sectors and jurisdictional" (Dubé, et al., 2014, p. 204). Initially, this policy coherence should occur by formulating overall governmental plans and strategies around a broadly formulated human issue. Several policy sectors should be involved, who together provide intersectional goals and plans through policy instruments. Furthermore, the WoG paradigm helps to elaborate different strategies to improve networking, cooperation and coordination (Dubé, et al., 2014, p. 204). This idea of policy coherence is primarily based on a top-down- and state-centric view, since it helps only the government to improve their governance skills. However, health issues are too complex to be solved only by the government (Bekker, Helderman, Lecluijze & Ruwaard, 2015, p. 6).

Consequently, the WoS paradigm can be seen as the answer to include more stakeholders in health issues. Whereas the WoG is primarily focused on the organization of the government themselves, the

WoS includes the overarching social, economic and political system, at different levels and different sectors (Bekker et al., 2015, p. 6): "The WoS paradigm views individuals and the plural organizations and institutions in different sectors that form state, market, and community as part of the same system in transformation through policy and action deployed on multiple scales" (Dubé et al., 2014, p. 206). The WoS paradigm fully embraces policy coherence by also including multiple stakeholders from different government layers and from different policy sectors.

3.5 Governance and the WoS paradigm

The question arises of how to use the WoS paradigm. Due to the decentralized character of Indonesia, the HIV/AIDS response is basically hard to govern, as many government levels work on this issue. Such complex relations among government levels requires effective public-policy management. Nowadays, most of the contemporary literature suggests use of free-market privatization, top-down centralized control, or bottom-up decentralized control as the main method (Andersson & Ostrom, 2008, p. 73–74). However, the WoS approach encourages the concept of polycentrism. This approach can be seen as a combination of centralized and decentralized governance, which require "enough central control to achieve coordination of a large system, and enough autonomy for locals to keep all subsystems flourishing, functioning, and self-organizing" (Dubé et al., 2014, p. 208).

3.5.1 Importance of local knowledge

Until the 1970s, the top-down view was used primarily as system to organize such issues. Given the observed failure of this centralized governance structure, decentralization has been introduced as an effective counterpart. Many scholars, including Elinor Ostrom, have demonstrated the value of adding formally linking local communities to the existing structures since, for example, local governments are more familiar with the local conditions and needs of their environment (Andersson & Ostrom, 2008, p. 72). Hence, the Indonesian government has also transferred responsibility for the HIV/AIDS response to a lower level by introducing decentralized policy (Heywood, 2013, p. 22). According to many scholars, this decentralized method of working has several advantages compared to the centralized government system. Firstly, local users are more likely to establish successful rules than central government systems, since they have local knowledge about the resource system, the participants, and so forth. Secondly, because of this local knowledge, local users are able to monitor the use of the resources in order to prevent abuse. Thirdly, there might exist a higher level of legitimacy when new policies are introduced by their own people (Andersson & Ostrom, 2008, p. 74). However, limitations of local governance do also exist. Some local governments are not capable of organizing themselves, for different reasons: It is too costly, they are afraid of a conflict among users, there is a lack of leadership or they fear being overruled by higher authorities. Given the complexity of the design tasks, some local governments are simply not capable of completing the tasks, and consequently they generate failure (p. 75). Such failure is also what can clearly be seen in the HIV/AIDS response in

West Java. There are several districts who perform significantly worse than others, since not all of the districts have the same level of resources and capabilities to establish an effective response (Ristya Rahmani, 2015, p. 15).

3.5.2 Polycentrism

These disadvantages of decentralized governance arrangements have been used by some scholars to justify preference of a centralized government structure again. However, Ostrom states that it is important to recognize the imperfections of all of the governance systems. In a decentralized system, the challenge is to establish institutions that support locals doing the right thing. A centralized system faces the challenge of devising rules that are effective and suitable for local circumstances. Polycentrism, introduced by Vincent Ostrom, attempts to encounter both challenges (Andersson & Ostrom, 2008, p. 76). Polycentricity examines the relationships among multiple authorities within overlapping jurisdictions (p. 71): "It is a system of governance in which authorities from different levels interact to determine the conditions under which these authorities are authorized to act" (McGinnis, 2011, p. 171). Polycentrism assumes that all outcomes on the local level are influenced by institutional arrangements on other government levels. Hence, a polycentric system of governance has the following components: Firstly, it is based on a multi-level approach where local, provincial, national and global governments are united. Secondly, it proposes to be multi-type, which means that it should include different kinds of jurisdictions. Thirdly, polycentric systems should be multi-sectoral, where stakeholders from public, private and community-based organizations cooperate to establish institutions. At last, multi-functionality is necessary to incorporate specialized units, for example provision, production, financing, coordination, monitoring, and sanctioning (McGinnes, 2011, p. 171).

3.6 Institutional diversity

The aim of this research is to explain the discrepancy in the implementation of the LKB program in the districts of West Java. Due to the complexity of HIV control and the influences of the related context, this objective requires input from a wide range of disciplines. The IAD framework developed by Elinor Ostrom helps to achieve this input. It contains the most general set of variables to examine a diversity of institutional settings, including human interactions among a wide range of stakeholders (Ostrom, 2010, p. 646). Therefore, the framework helps to research the HIV/AIDS programs from a polycentric perspective, since Ostrom agrees that many different stakeholders should be involved in an action situation.

3.6.1 Framework in general

The action situation is the main focus of this particular framework in which policy choices are actually made: "In this core component of the IAD-Framework, individuals, acting on their own or as agents of organizations, observe information, select actions, engage in patterns of interaction, and realize

outcomes from their interactions" (McGinnis, 2011, p. 173). After studying the initial structure of an action situation, there are two other steps that can be taken to understand institutional diversity better. Both steps require a look outside the action situation. The first step includes the detection of the exogenous variables that effect the structure of the action situation. These contextual factors contain three clusters of variables: biophysical and material conditions, attributes of community and the rules-in-use. These variables will help to examine the extent to which the context of the district influences the outcomes of the LKB program. The second step focuses attention outside of the action situation. As mentioned, Ostrom has agreed with the fact that decisions made at one level usually constrain decisions made at other levels. The Indonesian HIV/AIDS response is also multiple level. Decisions on the central level influence outcomes on the district level (Ostrom, 2005, p,58). The IAD framework is illustrated in Figure 7.

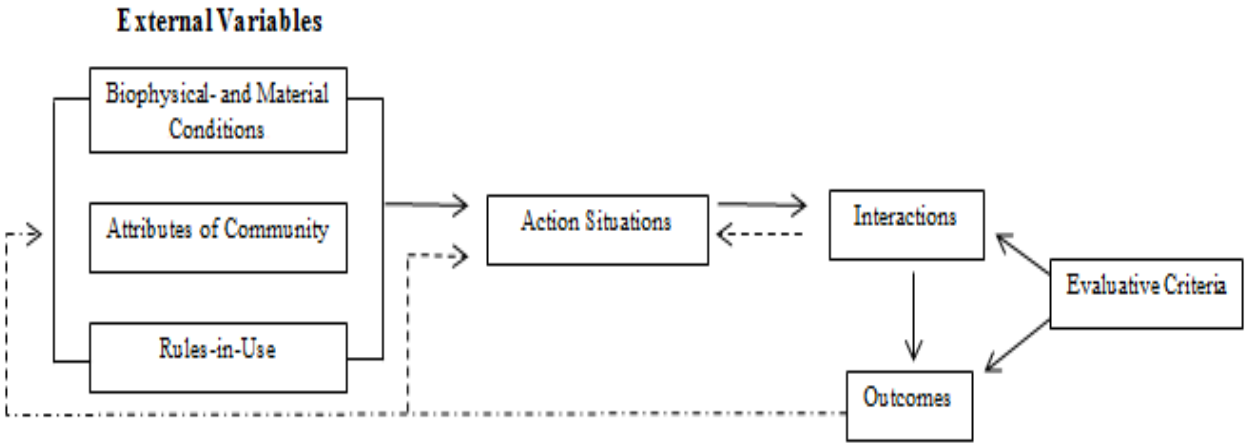

Figure 7: A framework for an institutional analysis (Ostrom, 2005, p.15).

3.6.2 Action situation

The action situation is the focal unit of analysis. An action situation can be seen as a meeting where interaction takes place between at least two individuals or actors who attempt to produce joint outcomes. As Ostrom (2011) describes an action situation as "tak[ing] place in a social space where individuals interact, exchange goods and services, solve problems, dominate one another or fight" (Ostrom, 2011, p. 11). Meetings between actors can be either formal or informal. Consequently, action situations within HIV response range widely from formal meetings of AIDS commissions at the central, regional or local level, to meetings with NGOs, or consultations between doctors and patients. Even though they differ greatly in size, number of participants, and degree of formality, all of these meetings are action situations in which actors make decisions (Heywood, 2013, p. 42). Action situations contain a specific structure for a set of variables that relate to each other (Figure 8).

First of all, there are several actors participating in the situation. These actors can be individuals, but also groups of individuals who function as a corporate actor. However, in this framework, groups have to be treated in terms of the individual people, linked to a series of additional situations within their own organization. There are several attributes of participants relevant for the analysis, including the number of participants, their status as an individual or as a team, and various individual attributes such as age, education and gender (Ostrom, 2011, p. 38). The second variable includes the specific position filled by the participants. Actors are assigned to positions, which makes it possible for them to start actions. Examples of positions are players, voters, judges, buyers, sellers, and so forth. Whereas the actors mainly include the background of the participants, the position says something about the work that they are supposed to do. Therefore, positions are the linking connection between participants and actions (Ostrom, 2011, p. 40). These actions, mentioned before, incorporate interaction between at least two individuals or actors, who come together to make decisions about interventions that should be taken to achieve a potential outcome. The decisions about the potential outcomes depend on the information available to the actors, the control each actor has over the whole situation, and the net costs and benefits thought to be associated with the decision (Ostrom, 2005, p. 32).

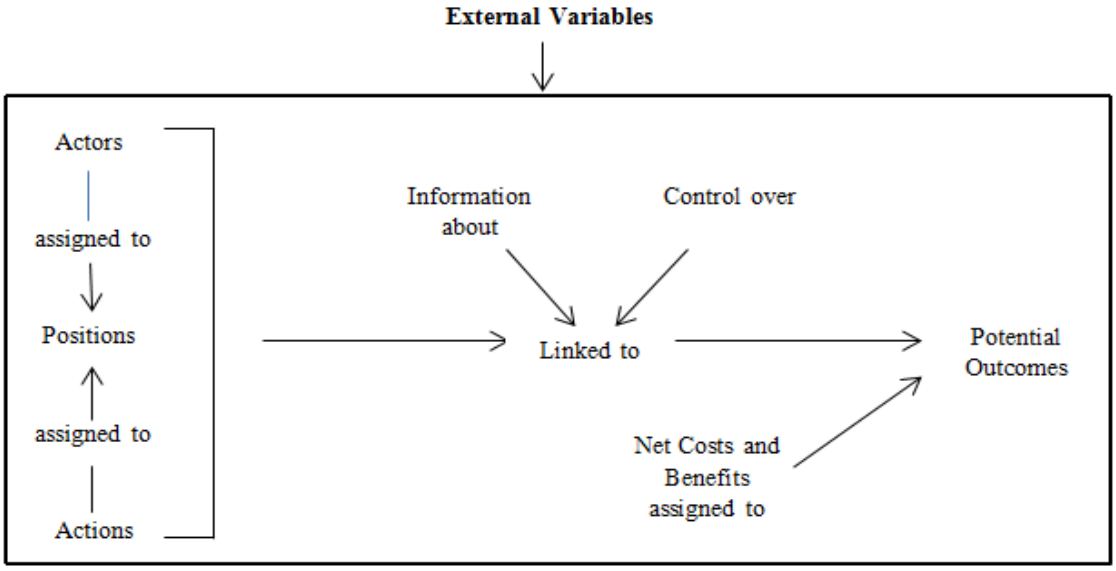

Figure 8: The internal structure of an action situation (Ostrom, 2005, p.33).

3.6.3 Exogenous variables

Stakeholders and their action situations are also subject to external influences by certain exogenous variables. These contextual variables are as follows: the biophysical and material setting, the norms and beliefs of the communities and the rules participants use to order their relationships (Ostrom, 2005). The assessment of HIV/AIDS response in the districts of West Java will take these external variables into account, since they might help to understand institutional diversity from a broader perspective.

The first external variable provides insight into the biophysical and material conditions. This set of variables helps to determine what kind of action situations are actually possible. It refers to all relevant constraints on any action situation created by the environment of the action situation. The circumstances of the district in which the action situation is located can significantly differ, with dissimilar outcomes resulting. Demographic and economic situation and the characteristics of the HIV epidemic within a district can strongly influence the effectiveness of control measures, and are therefore necessary to include in this particular contextual aspect of framework (Ostrom, 2005; Ostrom, 2011).

The second external variable includes the attributes of the community. This variable embraces all relevant aspects of the social and cultural context of an action situation (McGinnis, 2011, p. 175). Within this category, we can differentiate between several indicators. One important indicator is level of trust among stakeholders, since a higher level of trust might help to create more effective cooperation. Level of trust can be influenced by reciprocity. The expectation is that members of the community will reciprocate when they have cooperated within previous successful encounters. Another variable that might influence the attributes of the community is the common understanding of the core values or goals within a community.

Especially the last variable, the concept of rules, is an important variable that strongly influences the action situation: “Rules are shared understandings among those involved stakeholders that refer to enforced prescriptions about what actions are required, prohibited, or permitted” (Ostrom, 2011, p. 17). This concept can be seen as the set of instructions that helps to create the action situation within the HIV/AIDS response (Ostrom, 2005, p. 17). Rules can be both formal or informal and therefore can be unwritten or formulated by unofficial authorities (Ostrom, 2011, p. 18). Ostrom classifies seven types of working rules that are directly connected to the structure of the action situations (Figure 9).

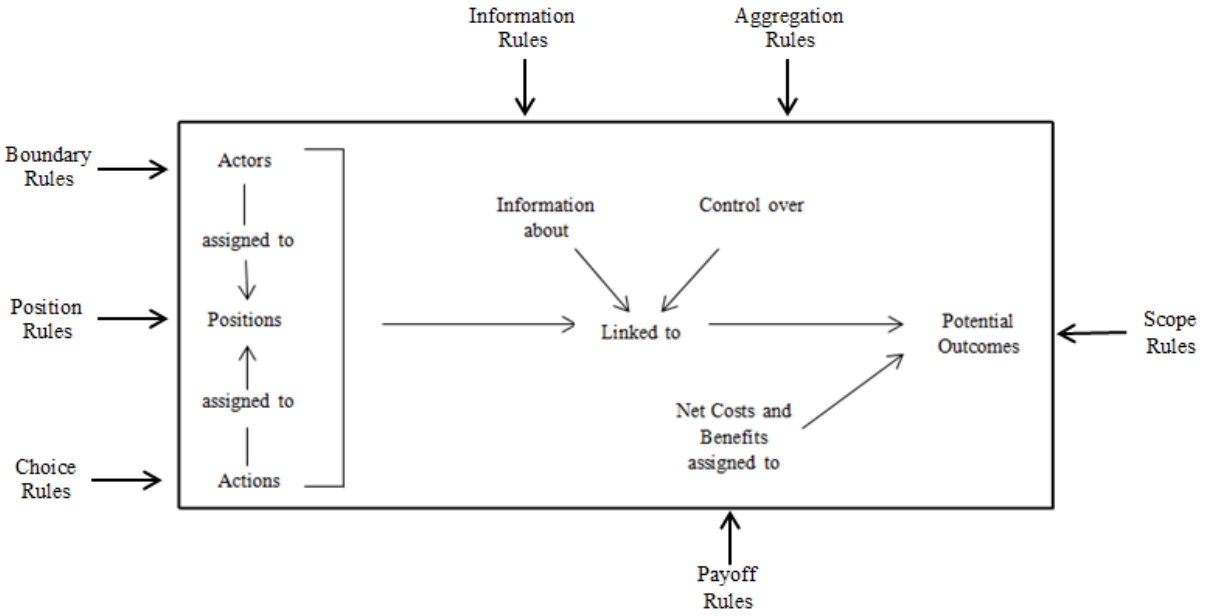

Figure 9: Rules that directly affecting all elements of the action situation (Ostrom, 2005, p.189).

The first set of rules is boundary rules, which help to determine who is eligible to join the action situation. These kinds of rules effect the number of participants and therefore also the resources and attributes that can be added to interactions. Furthermore, it contains also rules about the entry and exit conditions of stakeholders (Ostrom, 2005, p. 194). Global health problems need to incorporate stakeholders based on a multi-level and multi-sectoral approach. This set of rules, specifically, help in the research of the extent to which these essential elements are included in the HIV/AIDS response, as it gives insight into which actors are actually involved.

Position rules clarify positions within an action situation. This set of rules helps to clarify the specialized task of the involved stakeholders within the implementation of the LKB program. Whereas the boundary rules include only the appearance of stakeholders in an action situation, position rules help to define what they actually do (Ostrom, 2005, p. 193). Furthermore, they also give insight into changes of position among stakeholders (Ostrom, 2011, p. 21).

Choice rules are the third set of rules, which assign sets of actions that stakeholders in positions may, must, or must not take. These actions are dependent on the positions the stakeholders have taken within the HIV response in the past, as well as presently. Besides, there are some state variables that can influence the rules. In many bureaucratic situations, such as the Indonesian HIV response, none of the stakeholders are authorized to take action unless specific state variables determine these actions (Ostrom, 2005, p. 201). A civil servant, for example, is not authorized to decide what kind of medicine HIV patients should use, since only doctors have the permission to do this.

The fourth set of rules are aggregation rules. These rules effect the level of control that a stakeholder in a particular position can have in the selection of an action (Ostrom, 2011, p. 20). Most of the time, before a stakeholder enters the action situation, there are already many decisions made that influence the action situation (Ostrom, 2005, p. 202). This set of rules looks more closely at the features that can influence the action situation.

Information rules help to give insight into the information available to each position (McGinnis, 2011, p. 174). This information can be about the overall structure of the action situation, about the current state of individual stakeholders, about the previous and current moves of other participants or about stakeholders' own moves (Ostrom, 2005, p. 206). Firstly, this set of variables includes the obligation, permission, or prohibition to communicate with other actors at particular decision-making moments. Secondly, it concerns the content of the shared information and to what extent this information is available for all involved stakeholders. Thirdly, it includes the methods of sharing information and the language in which the information is provided.

The sixth set of rules contains the payoff rules, which specify how related benefits and costs are required, permitted, or forbidden to stakeholders (McGinnis, 2011, p. 174). These rules include the external rewards or sanctions related to actions that can be taken or received by actors. Examples of external rewards within the LKB program can be a payment to actors who attend meetings or extra budget, in case of good performance. Meanwhile, there might be also sanctions that can be imposed when stakeholders break rules.

Scope rules, the last set of rules, help to define the final outcomes of the action situation. Scope rules delimit potential outcomes by giving a list of actions that must, must not, or may be taken. This set of variables helps the involved stakeholders to understand why they actually work together and what priority they give to this issue. Table 3 lists the different kind of rules and the basic aim of these rules.

The aim component of each type of rule

Type of rule	**Basic aim verb**	**Regulated component of the action situation**
Position	Be	Positions
Boundary	Enter or leave	Participants
Choice	Do	Actions
Aggregation	Jointly affect	Control
Information	Send or receive	Information
Payoff	Pay or receive	Costs/Benefits
Scope	Occur	Outcomes

Table 3: The aim component of each type of rules (Ostrom, 2011, p.191).

3.7 Learning from differences

Local governments have the autonomy to organize their own responses, resulting in differences of effectiveness between districts (PRISMA, 2015, p. 6). The IAD framework supports research of the institutional setting in the districts. A comparison between the three analyses creates the possibility to discover the conditions of successful collaboration. A method that fits with the idea of learning from differences is experimentalist governance (EG), which is "an institutionalized process of participatory and multilevel collective problem solving, where the problems and the means of addressing them are framed in an open-ended way and subjected to periodic revision by various forms of peer review in the light of locally generated knowledge" (De Búrca, Keohane & Sabel, 2014, p. 2).

This type of governance generally includes two categories of actors. Firstly, central actors, who create the general policies and review the implementation process, and secondly, local actors, who have to accomplish these goals by adapting them to their local conditions. EG can be seen as a cycle of learning including numerous steps that continue constantly. Sabel et al. distinguishes four essential steps that have to be taken in this process of learning from differences (Búrca et al., 2014, p. 2). In the first stage, the central and local actors try to reach consensus on a broad framework with general open-ended goals. In the second stage, local actors receive broad discretion to pursue these open-ended goals in their own way. Local units are more familiar with local circumstances, and therefore, are more suitable to adopt the broad framework. However, as a condition of this autonomy, local units are obligated to report regularly on their performance, in the third stage. Finally, in the last, goals and practices created in the first stage are subject to routine re-evaluation.

This framework in particular helps to govern polycentric systems, such as are present in HIV/AIDS control. EG agrees that there must be enough central control to achieve the broadly determined policy goals, but also enough local autonomy to adapt policies to the local context. Experimentalist governance accommodates diversity in adapting general goals to varied local contexts, rather than imposing a one-size-fits all solution. The process of EG can be clearly seen in the actual HIV/AIDS response in Indonesia. The LKB program is the reference document for all the involved partners at all levels of government and within all sectors. This document provides the general framework with regards the response to HIV/AIDS. Thereafter, the implementation of this broad framework is left to lower-level involved stakeholders at the district level, since they are more familiar with the local conditions. These stakeholders may elaborate their own policies to the norms of the their own particular context, as long as they fit within the general framework. Consequently, differences exist in the functioning of HIV/AIDS programs between the districts. In order to learn from these differences, it is necessary to report and monitor across the contextual districts. In this thesis, the LKB program in three districts is extensively evaluated based on the IAD framework. A comparison of the three institutional analyses helps to discover the conditions for a successful collaboration. These conditions

should be used to improve the broad framework at the national level, afterward beginning again the cycle of learning from differences. Figure 10 shows the steps of experimentalist governance and how it is applicable to the current situation of Indonesia's HIV/AIDS.

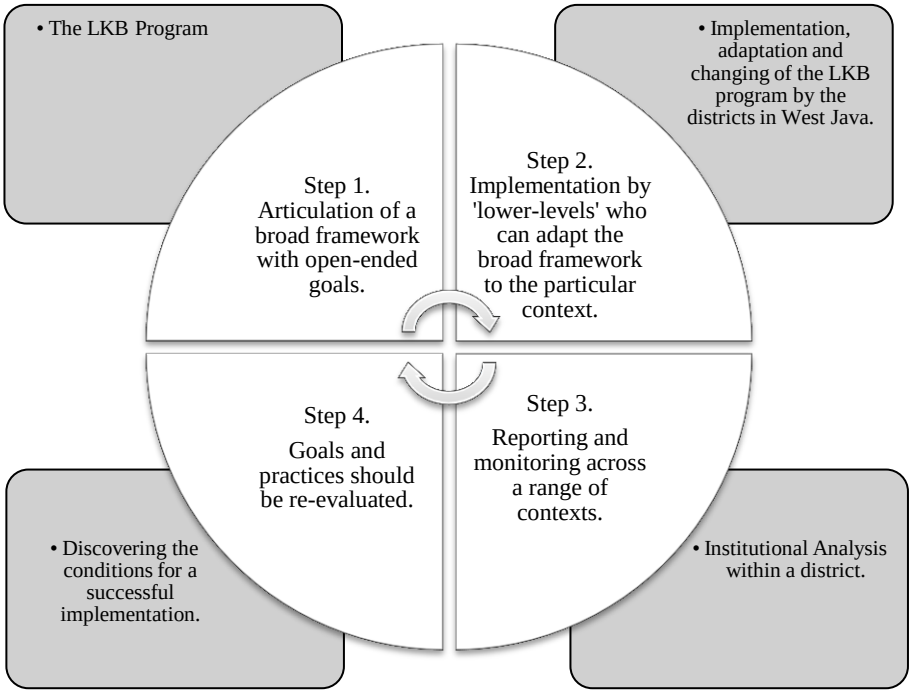

Figure 10: The circle of experimentalist governance applied to the LKB program in West Java (Búrca et al., 2014, p.2).

3.8 Theoretical framework

The Indonesian HIV/AIDS response has become more and more complex over the years. Today's trend is, namely, to involve a wide range of stakeholders, as government cannot solve this enormous problem alone. The WoS paradigm suggests collaboration with plural organizations and several institutions from different state sectors, market parties and civil society in one system. The LKB program is that particular program that should facilitate and strengthen this network of stakeholders. The previous chapter has shown that it is hard for some local districts in West Java to arrange this collaboration effectively. However, some districts are significantly more effective in collaborative response than other districts.

The key question of this research is, therefore, to explain the discrepancy between districts in West Java as regards the implementation of the LKB Program. Due to the complexity of HIV control and the influences of the related context, the primary research question requires input from a wide range of disciplines. The IAD framework developed by Elinor Ostrom can help to do this. It contains the most general set of variables to examine a diversity of institutional settings, including human interactions among a wide range of stakeholders (Ostrom, 2010, p. 646). It is, especially, the recognition the need to involve a wide range of stakeholders that makes this framework appropriate for this thesis.

Furthermore, Ostrom agrees on the fact that a decision made on one level usually constrains decisions at another levels. Consequently, polycentrism as proposed in the WoS approach can also be researched within this framework. Due to the comparable character of this thesis, a situation is created where stakeholders can learn from each other so that everyone benefits from optimal HIV/AIDS control. Consequently, the learning curve, grounded on EG, is part of the theoretical framework. The theoretical framework of this thesis is designed as follow in Figure 11.

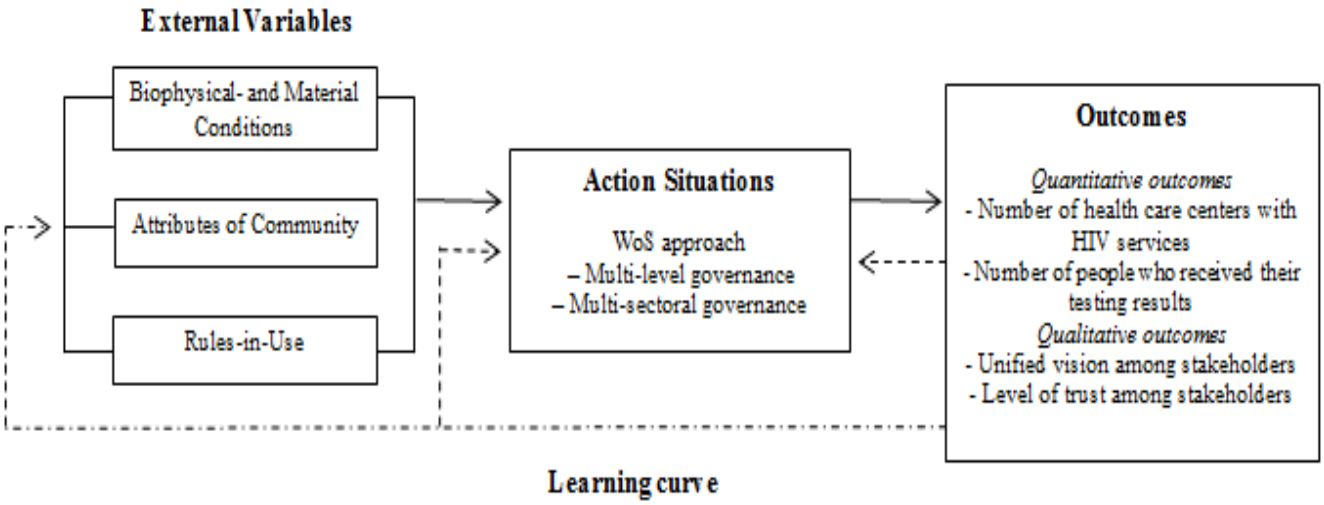

Figure 11: Theoretical framework that guides the answer of the research question.

Chapter 4 – Methods

4.1 Introduction

Before we can start with the empirical part of this thesis, the previously articulated theoretical assumptions have to be prepared for testing. Therefore, this chapter will function as a bridge between the theoretical and empirical parts of the thesis; as such, in this chapter I will elaborate on the multiple-case research design employed in this study. The choice for this research design is explained together with the case selection, data collection and data analysis in sections 4.2 through 4.5, respectively. Thereafter, the theoretical concepts are subject to the operationalization in Section 4.6 in order to render them measurable. Subsequently, the chosen methods are subject to discussion in Section 4.7. The chapter concludes with a summary in Section 4.8.

4.2 Research Design

A multiple-case study was employed in order to expound the differences in collaboration between stakeholders in three West Javanese districts: "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2003, p. 13). There are several advantages of qualitatively comparative cases studies that make this research design appropriate for the present research question. Firstly, a case study approach suits particularly well when the researcher is willing to understand what the studied group's social environment means to them and the way they behave in regard to this environment. These contextualized meanings are not possible as the subjects of quantitative research because only a small set of variables can be tested, which bring us to the second advantage of a case study. A case study allows a researcher to take a wide range of variables into account within single cases (George & Bennet, 2005, p. 19). Since this topic is quite unique, it is helpful to research the topic deeply instead of broadly. Due to this in-depth research approach, a case study provides a richly detailed and extensive description of the phenomenon (Van Thiel, 2014, p. 87). Furthermore, it helps to do an in-depth analysis of the evolving interaction processes and their outcomes (Boeije, 2005, p. 27). Many stakeholders in Indonesia work together on an effective HIV/AIDS response. A case study helps to clarify the interaction process between all the involved stakeholders and their associated outcomes in the selected districts. Although the internal validity increases with this approach, the external validity decreases, as results are less generalizable. Thirdly, case studies are more beneficial due to their applied nature. In applied research, the researcher attempts to contribute to the solution of a concrete social issue (Van Thiel, 2010, p. 99). This study embraces a clear problem concerning the HIV/AIDS response coordination in West Java. Therefore, there is no need to research other cases, since I want to discover LKB implementation practices for local stakeholders in West Java. To sum up, there are three concrete advantages of a case study: It

includes contextual conditions, provides more information, and more practically targets the existing problem.

Furthermore, this study took an interpretative approach, seeking to examine people's understandings from their own experiences. This inside perspective helps in research of the subjective meanings that respondents attach to their stories. Instead of focusing only on facts, this research attempt to understand the subjective meanings within the context in which people live (Hennink, Hutter & Bailey, 2011, p. 14; Geertz, 1973).

4.3 Case selection

The Indonesian HIV epidemic is interesting to research, as Indonesia is one of the few countries that still has a dramatic increase of new infections every year (UNAIDS, 2014, p. 354). Moreover, Indonesia was suitable for this research because of its decentralized government structure. This structure creates differences between districts, which can be used to learn and discover best practices. In addition, this study focused particularly on the province of West Java, as it has one of the highest absolute numbers of infected people (NAC, 2009, p. 15). Also in this province, annual numbers of new infections are predicted to increase significantly (PAC West Java, 2009, p. 5). Comparative research is also conducted on Bali, specifically with a comparison between the two provinces. It was interesting to make this comparison with Bali, as this island has a completely distinct cultural setting and a different HIV/AIDS approach. This thesis refers, therefore, several times to this article, as it helps to more accurately picture the HIV/AIDS context in Indonesia. The scholarly article is added to the Appendices (Damink, 2016).

The province of West Java is divided into 27 districts. Although all districts received LKB training, only 11 have implemented the program since the beginning in 2012. These 11 districts include six cities and five "rural" districts. The cities are relatively small if measured in square meters, but they are big when measured in population; the other districts, on the other hand, are much bigger in square meters but lower less population density. HIV cases per 10,000 people in the cities is much higher than in the rural districts (Ristya Rahmani, 2015, pp. 10–11). Furthermore, it was expected that the political situation and governance differ between cities and rural districts. Therefore, I chose to research both cities and rural districts in order to get a more comprehensive view of West Java.

4.3.1 A most similar systems design

Since differences among districts in HIV response exist, it is useful to research more districts in a multiple research design (Van Thiel, 2014, p. 89). A multiple-case study provides more powerful conclusions, as it expands the external generalizability of findings (Yin, 2003, p. 53). The selection of cases is made based on a purposive selection through analysis of documents and peer interviews. A

similar case design was employed in this study. With this approach, we attempted to compare districts that are as similar as possible in their economic, political and social situation (Hague & Harrop, 2010, p. 51). All districts are located in the province of West Java, which makes it likely to contain comparable contextual settings. However, within this similar-case design, contrasting cases regarding effectiveness are selected based on several variables (Van Thiel, 2010, p. 104).

The first step in the case selection procedure was to select one case with successful implementation, one district that is a middle-performer and one district in which implementation has failed. However, it might be precarious to choose the cases based only on the dependent variable, as it is hard to arrive at convincing proof of causality. There are many other reasons that explain why some districts perform better than others. Besides, would be hard to trace back the outcomes of certain processes to the original situations. Accordingly, the choice was made to select the cases mainly based on the independent variable, a decision that aligns with most similar system designs (Van Thiel, 2010, p. 104).

The first dependent variable in this research was the number of primary health care services with HIV/AIDS services per total number of primary health care services available in the city. A district can be considered effective when they have established more health care services within an HIV/AIDS department. The departments can be seen as the main entry points for people living with HIV, and therefore they are necessary for effective response. In order to make this variable more comparable between the cities, it was decided to demonstrate the HIV departments per total number of primary health care services. The second dependent variable was the number of people who received their testing results. The expectation was that a district performs better when they are able to get more people tested. The independent variables were based on the results of previous research by the PRISMA project, which is a project of NICHE. The two independent variables were the unified vision of HIV/AIDS and the level of trust among stakeholders (Ristya Rahmani, 2015, pp. 10–11). These selection criteria fit already within the main theme of this thesis: governance within the HIV/AIDS response. A unified vision and trust among stakeholders were both conditions that might influence the effectiveness of collaboration. The decision was made to select two districts with a strongly unified vision and a high level of trust, as well as one district in which these two criteria are not as well satisfied.

4.3.2 Three districts as case

The above selected variables helped to select three different cases. The following districts were researched: Bandung, Cirebon and Bogor. The table below makes it clear that Bogor and Cirebon can be considered the two districts that perform relatively well. According to previous research, both districts have proved to have a unified vision and a high level of trust among stakeholders.

Furthermore, Bogor has a full coverage of HIV/AIDS services in their health care services and Cirebon has a relatively high number of people who received their testing results. Bandung, in contrast, is the district in which the unified vision and trust among stakeholders are missing, which might be the reason for the low coverage of HIV services in the health clinics and the low number of tested people.

HIV/AIDS situation in the three chosen districts of West Java

City	HIV cases per 10.000 people	Primary health care with HIV/AIDS services per total number of primary health care available	People who received their resting results in percentage of the total population	Unified vision	Level of trust among stakeholders
Bandung	33.6	24 / 73 (32.9%)	19.737 (0.8%)	Low	Low
Cirebon	18.8	15 / 57 (26.3%)	24.285 (1.2%)	High	High
Bogor	27.5	24 / 24 (100%)	23.526 (2.5%)	Very high	Very high

Table 4: An overview of the three researched cities in the province of West Java (Ristya Rahmani, 2015, pp. 10-11).

4.3.3 Bandung

Bandung is the capital city of West Java, and with a population of more than 2.5 million it is the country's third-largest city. Due to the mountain landscape around Bandung, the colony capital of the Dutch East Indian company was moved from Batavia to Bandung. Temperatures are significantly lower than all other places in Indonesia, and the mountains and volcanoes that could be used as natural defense system made Bandung a better capital for Dutch governors. Over the years, Bandung developed itself into an important economic, social and cultural city as result of its voluminous natural resources. Bandung is nowadays well known as an attractive city for immigrants and travelers, due to the large number of hotels, restaurants and shops. Hence, Bandung has been nicknamed the Paris of Java. As almost all other districts in West Java, Bandung is also strongly influenced by the Sundanese culture, but the urban influence is clearly visible. People are more modern compared to other districts (Maharani, 2016). According to experts, Bandung can be considered one of the weakest performers. With 33.6 cases per 10,000 people, it belongs to one of the cities with the highest case-findings. Despite this troublesome fact, only 24 of the 73 hospitals include a specialized HIV/AIDS department. On top of that, unified vision and trust among stakeholders is lacking in Bandung (Ristya Rahmani, 2015, pp. 10–11). Although many policy sectors and NGOs are involved in the HIV/AIDS response, Bandung's government still has not reached any agreement on local regulations (DAC Bandung, 2015, p. 1).

4.3.4 Cirebon

Cirebon district is located in the northeast of West Java. Compared to Bandung and Bogor, Cirebon is a less developed city, since it does not have a key position in the economics, science and cultural sector. Furthermore, the Sundanese culture is clearly visible, which is combined with strong Islamic influence. Informal leaders, such as religious public figures, provide clear opinions about certain

topics that strongly influence many policies (Maharani, 2016). Although Cirebon is a smaller and less developed city compared to Bogor and Bandung, experts count them as a middle-mote performer. The number of people who have been infected is relatively low, and the number of people who have been tested is quite high. However, resources such as money, knowledge, and hospitals are still lacking. Nevertheless, the unified vision is shared among almost all important stakeholders, and there is a high level of trust (Ristya Rahmani, 2015, pp. 10–11).

4.3.5 Bogor

Bogor city is a middle-large city located in the province of West Java around 60 kilometers south of the Indonesian capital, Jakarta. Bogor, also known as "Buitenzorg," was during the Dutch colonial period a summer residence of important governors from the Netherlands. Partly because of this colonial history, Bogor has developed itself as an economic, scientific and cultural center in West Java. With a population of around one million people and a geographical size of around 120 square kilometers, Bogor can be seen as a city with high population density. Although the Sundanese culture is strongly embedded in the city's cultural history, it is becoming more influenced by Jakarta's urban style, due to economic relations (Maharani, 2016). According to experts, Bogor is considered one of the best performers in HIV/AIDS response in the province of West Java. Some of the stakeholders together invented the outlines of the programs. Consequently, all the 24 local hospitals include an HIV/AIDS department based on this program. However, based on the number of HIV infections, Bogor should be considered a middle-operator, with 27.5 cases per 10,000 people (Ristya Rahmani, 2015, pp. 10–11). Furthermore, the local government still has not established local regulations. The HIV/AIDS response is fully dependent on the commitment of the stakeholders who created together a local five-year strategy (DAC Bogor, 2015, p. 3).

4.4 Data collection

In this study, data triangulation was used in order to ensure validity (Vennix, 2010, p. 267). Interviews were the primary source of qualitative data, but additional observations took place and written documents were also analyzed.

4.4.1 Interviews

Semi-structured interviews were the primary data source in this research. In this deductive research, the interview questions were based on the operationalization of the variables derived from the theories and based on the information provided by experts (Van Thiel, 2014, p. 94). The interviews were built on an interview guide, where questions were formulated in advance. Nevertheless, it was possible to change the content or order of the questions to provide for the possibility of the respondent telling everything what they wanted to. The interview guides are included in appendices II and III. There are several reasons that I chose semi-structured interviews. Firstly, this way of conducting interviews

provides more diverse answers than those given by the interviewees. Secondly, open questions are more suitable for studying the context of the HIV/AIDS programs' implementation, because the interviewees have the opportunity to provide more examples and explain their own experiences and expertise. Thirdly, this academic domain, influencing factors for the functioning of HIV/AIDS programs, is not very well researched. In order to gain a better understanding of this topic, it is useful to start with this kind of interviews to explore the field in a broader sense. Due to the fact that this research was conducted in Indonesia, many language barriers arose. Respondents feel more comfortable speaking their own language, and consequently it was decided to conduct all interviews in Bahasa. The research assistants of the PRISMA project (Febrina Maharani & Wandira Larasati), who known this topic well, joined all the interviews to ask the interview questions. During the interviews, answers of respondents were translated directly into English. This translation made it possible to inquire further, and therefore satisfaction of the main aim of doing in-depth research in qualitative research was guaranteed.

In the early stage of this study, some pilot interviews with scientific experts were conducted to get familiar with the current situation. These interviews were open and lasted for two to three hours. Thereafter, districts and respondents were selected based on a "snowball recruitment" or "chain sampling." These methods of selecting respondents suits particular to get in touch with the most interested respondents within the field (Van Thiel, 2010, p. 55). Due to the high level of bureaucracy in Indonesia, some problems arose in arranging interviews with higher level authorities. In total, 20 respondents were interviewed in 17 in-depth semi-structured interviews among a variety of stakeholders, and the interviews lasted between one and two hours. An overview of the conducted interviews and the related codes is depicted in Table 5. These codes are used in further analysis. Appendix IV includes a more extensive interview overview, with a description of the respondents, the interviewers and the date and locations of the interviews.

Overview of interviews

Bandung (N=3)		**Cirebon (N=4)**		**Bogor (N=7)**		**Additional (N=6)**	
Respondent	*Code*	*Respondent*	*Code*	*Respondent*	*Code*	*Respondent*	*Code*
DAC	Ban1	DAC	Cir1	DAC	Bog1	Scientist	Exp1
DHO	Ban2	DHO	Cir2	DAC	Bog2	Scientist	Exp2
NGO	Ban3	NGO	Cir3	DHO	Bog3	Scientist	Exp3
		Kesra	Cir4	DHO	Bog4	Scientist	Exp4
				NGO	Bog5	DAC prov.	Pro1
				NGO	Bog6	NGO prov.	Pro2
				NGO	Bog7		

Table 5: An overview of the conducted interviews (N = number of respondents).

4.3.2 Content analysis

Content analysis is the second method to collect data, and with this method written documents were analyzed. This kind of analysis was used to collect facts and opinion about the HIV/AIDS response

and to reconstruct the arguments of stakeholders (Van Thiel, 2014, p. 110). There exists a wide range of documents and reports about this subject. Therefore, selection was made based on distinction between three different categories. The first group contained all the authorized documents provided by formal institutions, such as the WHO and the national and local government. Most of these documents are policy outlines and strategy plans, but some of these documents include also an evaluation of previous programs. The second group of documents contained previous research and advisory projects. During the years, a wide range of scholars ranging from different countries and different perspectives were involved in this issue. Some of them provided useful reports and scholarly articles that aided this research. The final group documents included the transcriptions of previous interviews done by the PRISMA research team. These interviews helped to give extra information and helped to avoid asking redundant questions to the stakeholders.

4.3.3 Observations

The last form of data collection was observation. An open observation format was applied, and according to this format the researcher is present in the research situation but does not interact with the subjects (Van Thiel, 2014, p. 70). Due to the Indonesian circumstances, there was no other choice for another kind of observation. Since I am not able to speak Bahasa, I could not participate in the research situation. However, it was useful to join to get an impression of the meetings. During the meeting, notes were made by me and someone who is able to speak Bahasa. In total, eight meetings were attended, two of which were organized by the PAC, three by local stakeholders in Bandung and only one for each of Cirebon and Bogor. An overview of the attended meetings is presented in appendix VI.

4.5 Data analysis

The conducted interviews were all voice recorded and completely transcribed in Bahasa, then translated into English. Detailed field notes were made to be used in combination with the transcripts. Furthermore, the notes made during the observations and the review of the existing documents were chronological summarized and divided into themes. After gathering the data, the transcripts were coded with both inductive and deductive coding strategies. This approach was decided on due to the fact that theory building occurs in an ongoing process between existing theories and new insights gathered as a consequence of the empirical data. However, since this research was primarily deductive, these codes were developed and derived from the existing literature. These codes are described in Section 4.6. Thereafter, inductive codes were developed based on the gathered data collection. Some respondents noted several issues that did not fit within the existing literature and in order to add this to the research, inductive codes were used. Especially these types of codes help researchers to create a deeper understanding of the meanings and thoughts of respondents, as these codes are more context-sensitive (Miles & Huberman, 1994; Thomas, 2006). Coding was done in Microsoft Excel and

Microsoft Word. To ensure a higher level of reliability, all transcripts were coded by me, and one of every sort of interview was double-coded by another researcher of the PRISMA research team. Differences in coding were discussed, and the code list plus coding was adjusted accordingly.

4.6 Operationalization

In order to take the step from theoretical concepts to empirical evidence, operationalization is needed. This section describes the process of transforming the theoretical concepts into observable and measurable concepts.

4.6.1 Main purpose of this research

As already mentioned, this research attempts to explain the discrepancy and to discover the necessary conditions for the success of LKB program in the districts of West Java. Due to the decentralized character of Indonesia, differences between local governments exists. This creates the possibility for the districts to compare and to learn from each other. The IAD framework was used as the main method to explain the institutional setting in three districts on West Java. The research question is summarized in Figure 12.

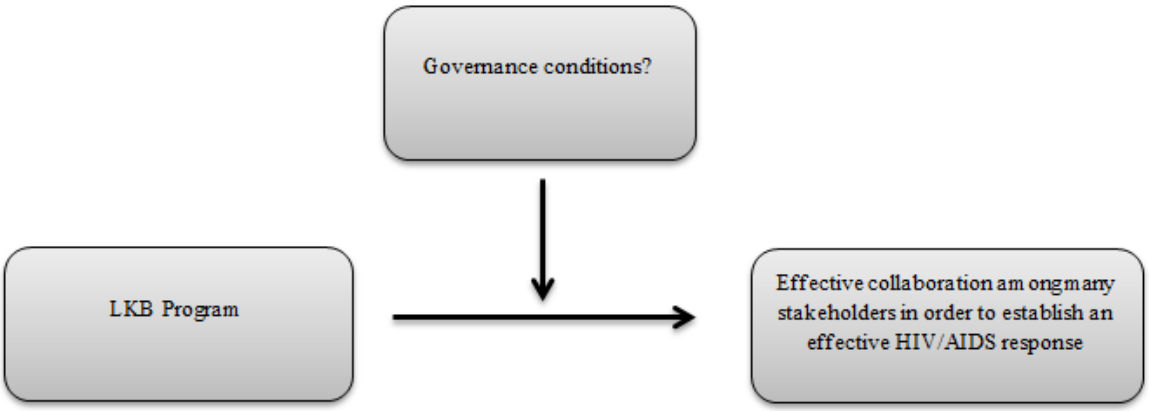

Figure 12: Conceptual model of the research.

The LKB program is proposed as guideline to create such an effective collaboration among many different stakeholders from public, private and civil society. However, the outcomes of current programs, and the LKB program in particular, are far from good. Furthermore, local stakeholder still do not have any idea how the LKB program should be implemented, as it is still a vague program. Therefore, the main aim of this research is to explain the discrepancy between districts in order to discover governance conditions for a successful implementation of the LKB program. This explanation might help to present HIV/AIDS programs as an effective answer to reduce or even stop the epidemic in the province of West Java.

4.6.4 External variables

The action situation is influenced by a set of external variables, which include the biophysical and material conditions, attributes of the community and the rules-in-use. The biophysical and material conditions helped to interpret the context in which the responses had to be organized. Every district has its own local circumstances that influence the implementation of the general response. These variables and the way they can be observed in the districts are listed in Table 6. Most of the variables were researched based on the content analysis, as most of the respondents were not familiar with the exact numbers for their district.

Biophysical- and Material Conditions

Variables	**Observations**	**Indicators**
Demographical situation	Total population	Number of people
	Geographical size	Km²
	Sub districts	Number of sub districts
Economic situation	Economic situation of government	GDP in billion IDR
	Economic situation of citizens	GDP in million IDR
	Human Development Index (HDI)	HDI number
	Incomes inequality	Incomes inequality number
Availability of resources	HIV/AIDS budget	District government budget in million IDR
		Local grant for DAC in million IDR
	Health services	Total number of local health clinics with HIV/AIDS services
		Total number of hospitals with HIV/AIDS services
	HIV/AIDS tests	Number of people who received their testing results
	Knowledge	High, middle or low
	Media	Yes or no

Table 6: Qualitative operationalization of the biophysical- and material conditions (Italic written codes are derived only from interviews, while other codes are primarily grounded on the theoretical framework).

The attributes of community are more focused on the social and cultural context in which an action situation is located. Table 7 depicts the variables and how they can appear in the local HIV/AIDS response. Especially the last set of variables, cultural repertoire within a district, might influence the action situation significantly. Indonesia is known as a country with many different cultures, which results in a wide range of norms, values and also languages.

Attributes of Community

Variables	Observations	Indicators
Trust	Extent to which actors feel confident to work together	High, middle or low
	Extent to which actors believe that agreements will be followed	High, middle or low
	Willing to help each other	High, middle or low
Reciprocity	Previous cooperation	Yes or no
	Satisfaction about the cooperation	High, middle or low
Common understanding	Given priority to solve the problem	High, middle or low
	Agreement about aim of the programs	Yes or no
Cultural repertoire	Religion	Islam or other
	Cultural background	Sundanese, Javanese or other
	Language	Bahasa, Sundanese, English or other
	Stigma and discrimination	Yes or no
	Working-style	Active or passive

Table 7: Qualitative operationalization of the attributes of community (Italic written codes are derived only from interviews, while other codes are primarily grounded on the theoretical framework). .

4.6.2 Collaboration among stakeholders

This research focused primarily on how governance can be used to improve the LKB program. The WoS approach includes public, private and civil society stakeholders all in a same system functioning on multiple scales. In order to research the appearance of this paradigm, an institutional analysis was conducted based on the IAD framework developed by Elinor Ostrom (2005; 2011). The action situation, where policy actions are actually made, is the main focus point of this framework. Action situations for this study might range from formal meetings of government officials to informal meetings between a doctor and an HIV-patient. Therefore, it was necessary to specify these kinds of situations first. In this research, action situations included only meetings of stakeholders who are involved in the policy-making process of the programs. Furthermore, only action situations between different kind of actors were taken into account. Consequently, meetings within a particular actor, for example meetings of the DAC, were not included. Although these meetings influence the action situation, this thesis focuses on governance, which is primarily based on collaboration between multi-sectoral and multi-level stakeholders.

The final external variable was the rules-in-use. This set of variables, especially, provided insight in the action situations and the resulting interactions. Therefore, I chose these external variables to describe collaboration among stakeholders in the three districts. Due to the high number of explanatory factors, a more extensive operationalization is provided Table 8. All rules contain different dimensions that can be observed in a particular way and can be measured, as depicted in the table below. Most answers to these rules are found in the interview transcripts.

Rules-in-Use

Variable	Theoretical definition	Dimensions	Observations	Indicators
Action situations	"Takes place in a social space where individuals interact, exchange goods and services, solve problems, dominate one another of fight" (Ostrom, 2011, p.11)	Kind of meetings	Description of meeting	Description of meeting
		Number of meetings	Number of meetings per month	1, 2, 3, 4, 5…
		Planning of meeting	Announcements of meeting	Clear, unclear, organized, double planned
		Setting of meeting	Formal or informal	Formal or informal
Actors - Boundary rules	"Specify how participants enter or leave the action situation" (McGinnis, 2011, p.174)	*Multi-sectoral involved partners*	DAC	Yes or no
			NGOs (number of NGOs)	Yes or no
			DHO (health department)	Yes or no
			Private sector	Yes or no
			Social welfare department	Yes or no
			Education department	Yes or no
			Religion department	Yes or no
			Department of justice	Yes or no
			Tourism department	Yes or no
			Transport department	Yes or no
		Multi-level involved partners	International organizations (WHO, UNAIDS, GlobalFund)	Yes or no
			National AIDS Commission (NAC)	Yes or no
			Provincial AIDS Commission (PAC)	Yes or no
			Communities	Yes or no
		Features of participants	Gender	Man or woman
			Background	Individual or organization
			Religion	Islamic or not
Positions - Position rules	"Establish positions in the action situation" (Ostrom, 2011, p.19)	Leadership	Appointed leader	DAC, DHO, NGO, or other
		Audience	Appointed audience	DAC, DHO, NGO, or other
		Participants	Appointed participants	DAC, DHO, NGO, or other
		Changes of positions	Replacements	Number of replacements
Actions - Choice rules	"Assign sets of actions that actors in positions may, must, or must not take" (Ostrom, 2011, p.19)	*Possible actions during meeting*	Presentations	Yes or no
			Discussion	Yes or no
			Evaluation	Yes or no
		Power	Decision-making	DAC, DHO or other involved stakeholders
Control - Aggregation rules	"Specify the transformation function from actions to intermediate or final outcomes" (McGinnis, 2011, p.174)	Control of other multi-level authorities by given regulations	Control by regulations	Yes or no
			Control by attending meetings	Yes or no
		Autonomy	Autonomy taken on district level	Yes or no

Information - Information rules	"Specify the information available to each position" (McGinnes, 2011, p.174)	Content of information	Number of data bases	Centralized or several data bases
		Obligation to share information	Obligation to share information	Yes or no
		Methods of sharing the information	Communication methods	Writtten or unwritten
		Using data	Other respondents use the received information	Yes or no
Costs and Benefits - Payoff rules	"Specify how benefits and costs are required, permitted, or forbidden to players" (McGinnis, 2011, p.174)	Sanctions	Penalties	Yes or no
		Rewards	Salary	Yes or no
			Compensation of the costs	Yes or no
Potential outcomes - Scope rules	"Specify a set of outcomes" (McGinnis, 2011, p.174)	Priority	Efforts that stakeholders put in their work	High, middle or low
		Clearness	Understanding of the whole process of HIV/AIDS response	Clear or unclear

Table 8: Qualitative operationalization of rules-in-use (Italic written codes are derived only from interviews and content-analysis, while other codes are primarily grounded on the theoretical framework).

4.7 Validity and reliability

The choice for this research design has important implications for this study. Reliability and validity are two important indicators to measure the quality of the research, and therefore I discuss them both in this section.

4.7.1 Validity

Validity refers to the influence of systematic errors on the investigation (Boeije, 2008, p. 145). Data triangulation was used to ensure construct validity. Although the interviews were used as major source of qualitative data, written reports were analyzed, and observations took place as well. Internal validity is sought by looking for dominant patterns and pattern matching. Cross-checking between all data collections increases explanatory leverage, because contradicting results between the analysis are likely to surface. Furthermore, the extensive operationalization done in this chapter improved the internal validity. The steps of operationalization facilitated the research of the theoretical concepts that supposed to describe the relationship between the independent and dependent variable (Van Thiel, 2010, p. 58). Since this research is limited to only three cases, its scope has a negative effect on external validity, as results are less generalizable. It is hard to say whether the gathered results in the three districts are valid in the other 11 districts. In order to improve external validity, a wide range of variables was determined to choose the most representative cases. Furthermore, external validity was sought by interviewing experts to find out whether the chosen districts are representative of all the 11 districts in West Java. However, within the case study arises the question of when a case study has to be generalizable. The goal of this qualitative research to provide in-depth knowledge rather than generalizable results. Furthermore, an advantage of a case study is its applied nature. This research attempts to contribute to an improvement of the HIV/AIDS response within the districts of West Java, which makes it less necessary to generalize to other provinces or countries. Furthermore, every situation is context-specific, making it risky to use results gathered in other districts (Bailey, 1992, p. 51).

4.7.2. Reliability

Reliability refers to non-systematic errors in measurement (Boeije, 2008, p. 145). Reliability is sought by clearly elaborating on the procedures followed to ensure repeatability. All the undertaken steps are included in the case protocol, which helps to make this research as transparent as possible. Also, all the interview protocols can be found in appendix VII. Aside from the interviews, this study makes use of official data sources. The data is, therefore, publicly available to anyone who wants to replicate this study. Moreover, for the content analysis within the districts, I have tried to use same type of documents. This effort increased reliability, as structures and features of the documents are the same for all districts.

This research strived to be as valid and reliable as possible. To this end, Bailey poses four elements that scientists can incorporated to make their case study more scientifically reliable. Firstly, a case protocol should be made, which is a formal document that includes a set of procedures used in data collection (Yin, 2010, p. 85). Consequently, I chose to include the case protocol for this research in the appendices. Secondly, it is important to pay extra attention during case selection. It is highly relevant to select cases that are representative of the researched group, and therefore Section 4.3 includes an extensive description of the case selection procedure. The selection of cases was made based on a purposive selection drawing on written reports and peer interviews. From the preliminary investigation of all 11 districts in West Java, a well-considered choice is was made. Thirdly, scientists should always be aware of possible research bias. Therefore, an extensive operationalization and coding procedure was employed in this research and checked by another researcher within the PRISMA research team. Fourthly, the research objective and the research methods should match in order to get the expected results. Interviews and observations are considered the main types of data collection in a qualitative research, since they help to yield in-depth analysis of a context-related phenomena (Van Thiel, 2010, p. 69).

4.8 Conclusion

This methodological chapter has formed the bridge between the theoretical and empirical parts of the study. The research design, case selection and data collection have been explained. Bandung, Cirebon and Bogor were chosen as cases based on their outcomes and their particular working style. This multiple-case research design, conducted based on an institutional analysis, made use of a wide variety of interviews with relevant stakeholders, policy documents published by different actors and observations of meetings within the selected districts. After gathering the data, transcripts were coded by employing both inductive and deductive coding strategies. This method of coding involves the interplay of deductive theoretical assumptions and inductive context-driven statements. The second part of this chapter has included the operationalization of the theoretical concepts. The subsequent chapter test the theoretical framework and perform the described analysis.

Chapter 5 – External influence on HIV/AIDS control

5.1 Introduction

This thesis primarily targets the initial structure of action situations in which stakeholders collaborate to realize outcomes. Nevertheless, these action situations are also strongly effected by external variables. The biophysical and material conditions and the attributes of community determine which action situations are actually possible. The aim of this chapter is, subsequently, to discover how these external variables influence the action situations. The chapter includes a contextual description of Bandung (Section 5.2), Cirebon (Section 5.3) and Bogor (Section 5.4). The results will be compared in a cross-section analysis in Section 5.5, with a summary following in Section 5.6.

5.2 Bandung

Bandung has developed itself as an important economic, social and cultural metropolis in Indonesia. The outcomes of HIV response are, however, disappointing. Despite the high number of HIV cases found in the district, Bandung has not established HIV services in all health centers, with the consequence that a small number of people have been tested (Ristya Rahmani, 2015, pp. 10–11).

5.2.1 Biophysical- and material conditions

With a population of almost 2.5 million people, Bandung is the third largest city in the country and the largest city in West Java. Its geographical size is 168,23 square kilometers, and it is divided into 30 sub-districts (West Java Central Bureau of Statistics, 2015). The economic situation of Bandung is evidently better than that of other districts in West Java. The regional GDP is 40,890 billion IDR, and the GDP per capita is 52.9 million IDR. The HDI is determined to be 78.89. However, not all people in Bandung benefit from the welfare of the city, as indicated by the high income inequality index of 0.477. A small portion of Bandung's richest population is responsible for almost all welfare ratings (b. Bandan Pusat Statistik, 2015).

The economic situation influences the availability of resources. The disposable HIV/AIDS budget is quite high in Bandung. The local grant that the DAC can use is estimated to be 825 million IDR per year. The district government budget, which is for most districts the main contributor, is unknown (P.C: Maharani, 2015). Despite the high budget, other resources such as health services, knowledge and technical equipment are not well provided. Several activities are undertaken to increase the people's knowledge of HIV/AIDS, but the results are, again, limited. Whereas experts and NGOs estimate that the knowledge level of citizens is extremely low, the PAC and DHO are somewhat less pessimistic. Authorities are simply still reluctant to give attention to HIV/AIDS in public (Ban1). Stakeholders are, in general, dissatisfied with the availability of resources. Although the economic

situation in Bandung is significantly better than in other parts of West Java, the availability of HIV/AIDS resources is still not wide enough: *"Our HIV/AIDS response is on track, but because of our limited human resources, we really have some troubles. There is a limitation in helping hands"* (Ban2).

5.2.2 Attributes of community

The attributes of community are more focused on the social and cultural setting (McGinnis, 2011, p. 175). The level of trust includes to what extent stakeholders feel confident to work together and to what extent actors believe that agreements will be followed up by each other. All stakeholders in Bandung have different perspectives about the collaboration. Whereas the DAC and the DHO are satisfied with each other as partner, the NGO is far from fulfilled. The DAC and DHO have, in general, a good relationship in which they are willing to help each other: *"Our cultural principle is remind each other, love each other and help each other, so if we can still help, remind, and tolerate, we will do that definitely"* (Ban1). The NGO, on contrary, does not recognize this principle in the collaboration. Many promises are made by the DAC and DHO, but most of them are not carried through (Ban3). However, the common goal of solving the HIV/AIDS problem is openly expressed. The three main stakeholders are all aware of the fact that this global health problem needs all their attention: *"For us, as a health office, HIV has one of the highest priorities in Bandung city"* (Ban2). Stakeholders in Bandung have been working together for a long time. The DAC and DHO are, again, satisfied with the entire cooperation, but the NGO is still critical. One of the critiques concerns the passive working style of the civil servants, caused by the Sundanese culture: *"If there is someone else taking care of the work, then Sundanese people tend to say 'go ahead and do it'"* said the NGO interviewee (Ban3). *"People dream of being civil servants, as they have easy work to do and they receive retirement money. So the intention is not to work, but to be a civil servant,"* explained another (Ban3). Besides the influence of the Sundanese culture, the Islamic religion also effects the action situation. HIV/AIDS-related activities need to be confirmed by Imams and the Koran, which means that people are also more reluctant to implement policies that contradict these doctrines (Exp1).

5.3 Cirebon

In this research, Cirebon is the only rural district, since the two other cases are both cities. Although Cirebon is much smaller in population density and is less developed than Bandung or Bogor, this district can be considered a middle performer. The number of people who have been tested is relatively high, and stakeholders have worked hard to create a strong network (Ristya Rahmani, 2015, pp. 17–18).

5.3.1 Biophysical- and material conditions

Cirebon has a geographical size of 1,071.05 square kilometers, which contains 40 sub-districts and a population of more than 2 million people (West Java Central Bureau of Statistics, 2015). The regional GDP is 9,382 billion IDR, and the GDP per capita is 12.2 million IDR. The HDI is consequently also only 65.53, but income inequality is low, at 0.284 (b. Bandan Pusat Statistik, 2015). Due to the relatively weak economic position of Cirebon, stakeholders possess only a small budget to use for HIV/AIDS. The district government budget is estimated to be 570 million IDR, and the local DAC budget is 300 million IDR (P.C: Maharani, 2015). The funding for AIDS is too limited, and therefore the DAC is far from satisfied with the availability of resources. An increasing number of service facilities is visible, but they are still too far away for the entire population of Cirebon to reach (Cir1). Knowledge of HIV/AIDS is also low, as many people are still not aware of the problem. The DHO receives regular emails with questions about the causes and effects of HIV. The DAC attempts to improve knowledge about HIV, but they face some challenges with people's openness. However, key populations are much better aware of the responsibility not to put themselves at risk of infection (Cir2). Cirebon has a clear lack of resources, but the three main stakeholders are motivated enough to deal with it (Cir1; Cir2; Cir3).

5.3.2 Attributes of community

The cultural setting of Cirebon combines cultures, and the setting tends to be more relaxed and open in this remote district than in the crowded cities. There is less influence of urbanization, and therefore people in Cirebon are more likely to speak a dialect that is a combination of Javanese and Sundanese (Maharani, 2016). Stakeholders feel, in general, confident about working together. People are willing to help each other, as they all understand that it is necessary to work on this issue. Most stakeholders have already been working on this theme for many years. Previous cooperation has happened often, and therefore everyone knows what to expect. The high priority given to work on this issue also contribute the effectiveness of related collaborations. All respondents agreed that HIV/AIDS is one of the most important health issues, as the impact on people is enormous. Due to the high priority and previous cooperation, stakeholders are satisfied with the relationship. However, stakeholders do report facing some challenges with the strong culture in this region: *"The religion is very strict and the culture is very strong"* (Cir2). The cultural setting has, for example, a high impact on the level of stigma and discrimination, according to the interviews: *"We should change the mind of the public that HIV is a taboo or a unusual matter. Our mission is to introduce HIV to the public as something that is not scary. We must reduce the high stigma"* (Cir1).

5.4 Bogor

Bogor, the second city of West Java, is considered a good performer in HIV/AIDS response. Stakeholders have established a solid collaboration system with a consequently unified vision and high

level of trust. HIV services are provided in all health centers, with the result that many people have received their testing results (Ristya Rahmani, 2015, pp. 10–11).

5.4.1 Biophysical- and material conditions

Bogor is a medium-large city with a population around 950,000 people. It spans 118.5 square kilometers and is divided into six sub-districts (West Java Central Bureau of Statistics, 2015). Despite the diverse functions of the city, official published numbers about the economic situation show that Bogor is not a strong economic performer. The regional GDP is only 5,710 billion IDR. This weak performance results in a GDP per capita of 19.2 million IDR, which is significantly lower than the average of West Java. However, the HDI is 73.1, and income inequality is 0.363 (b. Bandan Pusat Statistik, 2015). The economic situation also influences the availability of resources. Based on interviews, the district government budget is estimated to be 1,000 million IDR, and the local budget for the DAC is estimated to be 250 million IDR (P.C: Maharani, 2015). Although Bogor has a full coverage of HIV services in health centers, respondents are still worried about the level of knowledge among citizens. Still, many people do not see the necessity of guarding against risk of infection. In order to increase the awareness level of Bogor's citizens, the local government has actively attempted to give attention to HIV in media sources, as indicated by one interviewee: *"We made a series articles for newspapers, so that everyone reads that and everyone knows how big the problem is in Bogor"* (Bog3). In general, respondents are satisfied with the amount of resources that they can use in their HIV/AIDS response.

5.4.2 Attributes of community

Bogor is known as a multicultural and diverse city (Maharani, 2016). Despite its different cultures, stakeholders have reached an unified vision and high level of trust (Ristya Rahmani, 2015, pp. 17–18). Respondents are, therefore, all satisfied with the relationship between each other. They all understand that cooperation is essential, as none of them can handle this enormous problem by themselves: *"We built together, because everyone feels the need of helping each other"* (Bog4). This high level of collaboration might be the result of the previous cooperation stakeholders have had with each other. For many years, the same stakeholders have been involved, and therefore everyone knows what they can expect. The high level of satisfaction is also the result of a common understanding. All respondents prioritize the HIV/AIDS issue, and consequently all stakeholders are willing to work on it. Bogor is also strongly influenced by the Sundanese culture and the Islam. Although respondents agree with the fact that this cultural influence can lead to barriers, these barriers definitely do not present serious impediments in Bogor. *"Here in Bogor it is very peaceful,"* stated the DAC (Bog1), with another affirming that *"Religion can be a problem in another region, but here not anymore"* (Bog3). However, the DHO's activities do not always agree with religious doctrines, and they are still aware of the fact that most interventions contradict Islam. Condom distribution, for example, is still a

controversial theme. Most of the people do not see the necessity of it, as unmarried people are thought not to have sex. Most of these challenges are overcome by the stakeholders as a result of a good communication and a cooperative style, said one of the interviewees. One, for example, said, *"Now we are all close friends although we come from a different backgrounds"* (Bog3).

5.5 Cross-sectional analysis

The contextual setting in the three districts is extensively described and all results summarized in Table 9. This section contains a cross-sectional analysis that helps to clarify how the context influences the implementation of the LKB program.

The demographic situation is the first determining factor. Whereas Bandung and Bogor are both cities, Cirebon is a rural district, and that is the reason for its the enormous geography. Cirebon is, compared to the two other cases, almost eight times bigger (West Java Central Bureau of Statistics, 2015). The large geographical size is one of the biggest challenges for stakeholders in Cirebon, as it is harder to reach the entire population. Although modern media have increased the possibilities, Cirebon still faces challenges to spread information about HIV and AIDS. Furthermore, the expanse of the district makes it difficult to organize meetings with relevant stakeholders from all parts of the district (Cir1;Cir2;Cir3). Another remarkable point in the demographical setting is the high number of sub-districts in Bandung. Although Cirebon has almost the same number of sub-districts, Bandung is much smaller. The comparison between Bali and West Java makes it clear that it would be easier to govern fewer districts (Damink, 2016, p. 13), and therefore, the expectation is that its size obstructs collaboration in Bandung.

The second determining factor of the contextual setting is the economic situation. Bandung is clearly in the best economic position, as both the GDP as the HDI are significantly higher than in other districts. The economic situation between Bogor and Cirebon is more comparable, although Bogor performs slightly better (b. Bandan Pusat Statistik, 2015). The good economic situation in Bandung effects also the budget that is available for HIV response. Bandung has significantly more money to spend than Bogor and Cirebon (P.C: Maharani, 2015). However, Bandung's higher budget does not result in better outcomes. The total number of local health services that provide health services and the number of people that received their testing results is the lowest of the three cases. Moreover, the number of infected people per 10,000 people is, at 33.6, the highest, and the level of knowledge among citizens is very low (Ristya Rahmani, 2015, pp. 10–11). Consequently, the conclusion can be made that a better economic situation and greater resources do not directly result in better outcomes.

The disappointing outcomes of Bandung can be linked to the attributes of the community. There is an extremely low level of trust among stakeholders, which may be the result of lack of experience and

previous cooperation. However, the stakeholders do all see the necessity to work on this health issue, although there is still no agreement about how it should be done (Ban1; Ban2). On top of that, civil servants have a very passive working-style (Ban3). Both stakeholders in Bogor and Cirebon have already worked on this topic for many years. During this time, the level of trust and reciprocity has increased significantly. However, all districts face some challenges with existing Sundanese and Islamic culture.

Overview of the external variables in the three districts

Variables	Observations	Indicators	Bandung	Cirebon	Bogor
Biophysical- and material conditions					
Demographical situation	Geographical size	Km² (2010)	167.29	990.36	118.50
	Total population	Number of citizens (2010)	2.394.873	2.067.196	950.334
	Sub districts	Number of sub districts (2010)	30	40	6
Economic situation	Economic situation of government	GDP in billion IDR (2013)	40890	9382	5710
	Economic situation of citizens	GDP per capita in million IDR (2013)	52.9	12.2	19.2
	HDI	HDI (2014)	78.89	65.53	73.10
	Incomes inequality	Incomes inequality (2014)	0.477	0.284	0.363
Availability of resources	HIV/AIDS budget	District government budget in million IDR (2014)	Unknown	570	1.000
		Local grant for DAC in million IDR (2014)	825	300	250
	Health services	Total number of local health services with HIV/AIDS services (2014)	24 out of 73 (32.9%)	15 out of 57 (26.3%)	24 out of 24 (100%)
		Total number of hospitals (public and private) with HIV/AIDS services (2014)	8 out of 8 (100%)	2 out of 2 (100%)	1 out of 1 (100%)
	HIV/AIDS tests	Number of people that received their testing results (2013)	19.737 (0.8%)	24.285 (1.2%)	23.526 (2.5%)
	Knowledge	High, middle, or low (2015)	Low	Middle	High
	Media	Yes or no (2015)	No	Unknown	Yes
Characteristics of the HIV epidemic	People living with HIV	HIV cases per 10.000 (2012)	33.6	18.7	27.5
Attributes of community					
Trust	Extent to which actors feel confident to work together	High, middle or low	Low	High	High
	Extent to which actors believe that agreements will be followed up	High, middle or low	Low	High	High
Reciprocity	Previous cooperation	Yes or no	Yes, but a lot of changes in positions	Yes	Yes
	Satisfaction about cooperation	High, middle or low	Low	High	High
Common understanding	Given priority to solve the problem	High, middle or low	High	High	High
	Agreement about the main aim	Yes or no	No	Yes	Yes
Cultural repertoire	Religion	Islam or other	Islam	Islam	Mainly Islam, but also Christian
	Culture	Sundanese, Javanese, mixed or other	Sundanese	Mix of Javanese and Sundanese	Mainly Sundanese
	Language	Bahasa, Sundanese, English	Bahasa	Dialect	Bahasa
	Stigma and discrimination	Yes or no	Yes	Yes	Yes
	Working-style	Active or passive	Passive	Active	Active

Table 9: An overview of the context in which the three researched districts are located.

5.6 Conclusion

This chapter has provided the contextual description of the three researched districts based on several external variables. The demographic situation influences the network of stakeholders as a larger geographical size and more sub-districts makes it harder to work together efficiency. The economic situation, on contrary, does not effect LKB programs' effectiveness. Although the comparison between West Java and Bali created the expectation that a better economic situation and more availability of resources contribute to better HIV/AIDS control, the contextual analysis of Bandung have shown something different. Bandung is in a much better economic position and possess a much higher HIV budget, although the outcomes are still disappointing. Thus, it must be something else that contributes to an effective implementation of the LKB program. This chapter has also shown that the better performing districts have created a more beneficial social and cultural setting for stakeholders. Both Bogor and Cirebon have a higher level of trust, a better common understanding and more experience in previous collaborations. Presumably, the social and cultural setting influence the implementation of the LKB program positively. Therefore, it is useful to have a closer look at the collaborations among stakeholders and the realized networks in the next chapter.

Chapter 6 – Meetings in the HIV/AIDS control

6.1 Introduction

The HIV/AIDS problem is hard to manage since many different stakeholders needs to collaborate. Private actors, the civil society and governments are all essential in the organization of Indonesia's control. However, previous chapters have shown that these collaborations are not so easy to arrange. Especially Bandung and partly Cirebon face challenges to optimize the network of stakeholders, while Bogor seems to do this better. The aim of this chapter is to elaborate on the action situations in the three districts in order to understand how the differences in effectiveness arise. As mentioned before, the rules-in-use are primarily used as method to describe these situations (see Figure 9). The districts will be systematically described based on the rules-in-use Section 6.2, Section 6.3 and Section 6.4. The three institutional analyses will be compared in Section 6.5 to discover the conditions of successful collaboration within the LKB program. This chapter ends with some suggestions for improvement in Section 6.6 and a conclusion in Section 6.7.

6.2 Bandung

Although Bandung possess enough resources to respond effectively to HIV/AIDS, it is the district with the worst performance. Stakeholders are not able to reach a unified vision, and the level of trust and satisfaction in collaboration is low (P.C.: Maharani, 2015; Ristya Rahmani, 2015, pp. 10–11). In this section, the collaboration between stakeholders will be further researched based on a description of the action situations and the rules-in-use.

6.2.1 Meetings in the HIV/AIDS control

Many different meetings among several stakeholders are organized in Bandung, ranging from internal meetings in the DAC or DHO, meetings with the three main pillars in HIV response to meetings that even include many policy sectors. However, all respondents reported considering the quarterly meeting to be the most relevant. This meeting among different actors takes place every three months. The DAC interviewee explains the meeting: *"In this coordination meeting we want to evaluate the progress of the programs to see whether it has been going well and what needs to be changed"* (Ban1). In between there are also some small meetings, but these are not systematically planned (Ban1). The participants expressed disappointment in the planning and coordination of meetings, with the NGO saying that *"The agendas of the three main pillars in the HIV/AIDS response still overlaps, and all of them are just doing what they want to do"* (Ban3). It has happened that two stakeholders have organized meetings at the same time with the consequence that they cannot attend each other's meetings (Exp1). Due to the lack of commitment among stakeholders, interaction takes mainly place

in a formal way. Stakeholders do not know each other well enough to communicate in an informal setting (Ban1; Ban2; Ban3).

6.2.2 Actors and boundary rules

Boundary rules help to determine which stakeholders are actually involved in the HIV/AIDS response. The quarterly meeting is attended by several multi-sectoral stakeholders. The DAC and DHO, as well as the NGOs, are the most relevant contributors (Ban1; Ban2; Ban3). The policy sectors are, on the contrary, less involved with the HIV/AIDS issue. As the DAC put it, *"The other policy sectors just put HIV/AIDS handling in between other things because it is not the main thing in some of the offices"* (Ban1). Nevertheless, the DAC attempts to involve other policy sectors actively, as they agree on the fact that the HIV/AIDS issue needs to have multi-sectoral attention. In Bandung, the following policy sectors attend meetings: social office, education office, youth and sports office and the family planning bureau (DAC Bandung, 2012, p. 4; Observation 1). The local HIV/AIDS strategy is, however, determined by only the DAC. Some respondents consider this restricted control of strategy as the reason for the weak involvement of the policy sectors (Ban3). Since Bandung is known as economic center, the so-called corporate social responsibilities are also involved and result in important financial donations. Instead of paying tax, companies have the opportunity to donate money to social issues like this. Originally a Dutch company Friesche Vlag provides, for example, free baby milk to children from 0 to 3 years old who are infected with HIV (DAC Bandung, 2012, p. 5).

Besides multi-sectoral partners, Bandung's meetings receive some input also from international, national and provincial governments. Although experts, the PAC and provincial NGO recognize the important role of the WHO and UNAIDS, whereas district governments experience this international involvement differently. Bandung's three main stakeholders all know that these international organizations are involved with HIV/AIDS, but they do not give direct input at meetings. Contribution of the WHO and UNAIDS is limited to providing money and other resources. The role of the NAC and PAC in the local response is also not very involved. The DAC has invited both commissions regularly, but it is rare that the NAC attends meetings, even though the distance from the NAC's headquarter to the DAC is not great (Ban1). The NGO even states that the control function of the PAC is completely missing. Only three people from provincial level are able to be involved, but they all do not contribute to the response. A lack of commitment between the provincial- and local levels is clearly missing, and the PAC does not have the capability to control local governments. This reality was reflected in the interviews, with the NGO interviewee summarizing, *"Although PAC really tries to help us, their impact is minimal"* (Ban3).

6.2.3 Positions and position rules

Now that we know who is involved in the action situation, the question arises of what they actually do. Position rules help to answer this question by separating the actions of the involved stakeholders into three different positions: leader, participant or audience. It is also this set of rules that provides insight into the changes of positions. In Bandung, the position of leader depends on the stakeholders who organize the meeting. Consequently, the DAC and DHO can both be leaders in HIV/AIDS response. The NGOs and the policy sectors, on the contrary, miss the presence of a leader (Ban3). The respondents also do not agree about whether other stakeholders, such as the NGOs and the policy sectors, are participants or audience. Both the DAC and the DHO see the role of the other stakeholders as being participants. Every stakeholder needs to bring input to the discussion, and therefore active participation is required (Ban2). However, it is again the NGO that undermines this view. The NGO considers the role of other stakeholders to be that of merely an audience. Policy offices and NGOs only listen to the presentation, and afterwards they do not give any input (Ban3). This might be the result of a large number of changes in positions. All respondents commented on fast job replacement levels in the policy offices as one of the main problems in the collaboration. The situation was exemplified by the NGO respondent: *"Sometimes person A came to a meeting and person B will come to the next meeting, and then person C next. So the program never really goes well. Nobody knows where the entire HIV response is about"* (Ban3). Due to the fact that participants are not familiar enough with the HIV/AIDS problem, the organizers have to repeat basic knowledge over and over, with the result that nothing can be discussed in any depth.

6.2.4 Actions and choice rules

The previous two sets of rules provided insight into the involved stakeholders and their positions. The next question facilitates an understanding of what stakeholders actually do with the possibilities of joining the action situation. It elaborates further on the following potential actions: presentations, discussions, decision-making and evaluation. The quarterly meeting in Bandung is primarily dominated by presentations (Observation 1), which were described by the interviewees: *"Presentations, yes. Discussions, I do not know. It is usually just a presentation about what has been done and about the objectives, things like that,"* said one (Ban3). The DAC and DHO do both agree that presentations are essential for other stakeholders to understand the HIV control, a conviction that one interviewee summed, *"Without a good presentation, stakeholders have for sure no idea what to do"* (Ban2). However, the NGO prefers to have an intensive discussion, one of the NGO respondents said: *"I am a former civil servant, so I always require a discussion at the end, but there is not. Even they do not have a question-answer session for the participants to ask about arising problems"* (Ban3). Decisions are also not made during these meetings. The direction of the entire HIV/AIDS control is already decided by the DAC and DHO before meetings (DAC Bandung, 2012, pp. 1–3). NGOs and other participants in the meeting are not asked to deliver any input concerning the previous

taken decisions (Ban3). The evaluation is also only discussed as part of the presentation, without any possibility to question it.

6.2.5 Control and aggregation rules

Decisions are also influenced by stakeholders from outside the action situation. International, national and provincial stakeholders all create their own strategic plans that effect the action situation on the local level. Aggregation rules is the category that includes these control aspects. Although international development partners do not provide direct input during meetings, respondents do all feel some control. The WHO, for example, invented the LKB program and organized workshops for local advocates (Pro1). The NAC has also control over the local response, as it composes every five years a strategic plan that includes a vision, mission and objectives. The NAC prioritizes the organization of responses by local decision makers above centralized and coordinated response. Therefore, Bandung's stakeholders have discretionary freedom to adopt the action plans to the epidemiological situation (NAC, 2014, p. 5). The PAC's function is also to provide guidelines and, furthermore, to assist local governments in advocating to make policy sectors more aware of the HIV/AIDS problem (Ban1). Higher-level authorities attempt to intervene in Bandung's policies, but local stakeholders are not completely open to this. However, the local stakeholders are not able to reach a unified action plan, and therefore the action situation in Bandung is very much controlled by other authorities. It is, especially, GF that gives strong direction to the HIV/AIDS response in Bandung. The strategy plan for Bandung, created by the DAC, is almost completely based on input from international organizations (DAC Bandung, 2014).

6.2.6 Information and information rules

The sixth set of rules helps to give insight into whether information is available to stakeholders. This variable includes the following dimensions: The obligation to share information, the content of information, methods of sharing information and whether information is used by others. According to the head of the DHO department, information about the HIV/AIDS epidemic is simple to receive, as the database is open to all interested stakeholders: *"There is only one database in which everyone can add their data and which will be shared to everyone afterwards"* (Ban2). However, neither the DAC nor the NGO recognize this openness of the DHO. It is correct that there is only one database, but this database is not as open as the DHO says it is, according to interviewees, one of whom said, *"We can only send an e-mail about data, but then these e-mails are not replied to, even after quite a while"* (Ban1). The NGO is even more critical of information sharing by the DHO. The program manager of the NGO is convinced that the DHO hides important information about the spread of the HIV virus. The NGO needs the data to make their programs more efficient, but they only receive it during presentations in meetings (Ban3). There are some possibilities to receive data before these meetings, but the DHO almost never replies to this request (Ban1). Due to the last-minute data sharing,

stakeholders are not able to include information in their own programs. The NGO and DAC use the data provided in the presentations of the DHO, but the quantity and quality of information is low, which means that their actions are not based on the received data.

6.2.7 Payoff rules

The payoff rules help to decide which actions are required, permitted, or forbidden to stakeholders. These considerations are based on the sanctions, rewards and compensations that can be imposed by actors (McGinnis, 2011, p. 174). All stakeholders agreed that sanctions do not exist in Bandung. Even when some policy sectors do not perform as expected, neither the DAC nor DHO can impose consequences. However, the head of the DHO explained that it is sometimes necessary to talk openly about their mistakes: *"We have not imposed any sanctions yet, but sometimes a social sanction will, hopefully, change something"* (Ban2). Rewards, by contrast, were favored by all stakeholders, as they can help to improve stakeholder actions and related outcomes. *"We want to give some rewards for people who contribute a lot to the HIV problem,"* expressed one (Ban1). And it is also the DHO that sees the value of rewards, with a DHO representative saying, *"There must be a pride. At least you should thank them during the meeting. I will announce that this is a good performer. Let's give applause!"* (Ban2). Besides social rewards, the DHO works also on material rewards such as certificates and higher budgets. *"I already planned to make a certificate. It is not expensive. It is only 10,000 IDR, but just a certificate is very important. It will change, what I experienced is that it changed"* (Ban2). The NGO confirms the beneficial result of appreciation, summed in the following statement: *"Giving appreciation to people is very important to motivate them better"* (Ban3). Furthermore, it must be mentioned that all stakeholders who attend meetings receive transport money, a small salary and a very luxury lunch (Observation 1). The expectation is that stakeholders would not attend meetings without any compensation.

6.2.8 Potential outcomes and scope rules

The potential outcomes and the scope rules are the final set that helps to clarify the institutional diversity in the HIV/AIDS response. In theory, scope rules specify a set of outcomes. However, in this research the outcomes have already been used as method to select the three districts, and they are repeated in Chapter 5. However, the unified vision and the level of trust were researched two years ago, and therefore it might be useful to do this research again. The scope rules are operationalized to investigate the clarity of the LKB program, the priority stakeholders give towards this issue and the level of unification of vision. The interviews posed questions about whether stakeholders are familiar with the LKB program. The DAC and DHO are both convinced that they know what to do. Besides their awareness of their position and function in the entire response, they also understand the content of the plan. The DAC is, namely, the main writer of the entire plan. Although the DHO has contributed in limited ways to the strategy plan, the head of DHO is sure that his department knows

what to do. However, the DAC is not certain about other policy sectors: *"The DHO is strongly connected to the HIV problem, but other policy sectors are not always aware of the importance to respond,"* articulated the DAC interviewee (Ban1). The DAC expects that some policy sectors do not understand what their role and function is. This expectation is confirmed by the NGO, a representative of which said, *"When we asked them what are the HIV/AIDS programs. Nobody can answer it correctly. And if they don't even know what it is, how can they make it work?"* (Ban3). The lack of understanding of the programs by especially the policy sectors results also in a lower priority level. The DAC, DHO and NGOs all give high priority to solving this enormous problem, but some policy sectors do not see the high need. *"I think there are two types of offices: One that supports everything, and one that does not really support. These offices need to be reminded. If we don't remind them, they will forget"* (Ban1). Stakeholders also do not confirm a unified vision. Although both the DAC and the DHO give a high priority to HIV/AIDS, a unified vision is still lacking. All three stakeholders contribute in their way to this issue, and the NGO is far from satisfied with the entire response. Thus, the DAC, DHO and NGO do all know how they can respond to HIV/AIDS, but the policy sectors are still behind. They still do not give a high priority to work on this issue, although they are needed in order to respond on a multi-sectoral level.

6.2.9 Précis

Bandung organizes several meetings for a wide range of stakeholders. The quarterly meeting is considered the most important meeting, as all three main pillars and several policy sectors are present (Ban1; Ban2; Ban3). However, the NGOs have some critiques of the organization and coordination of these meetings. It sometimes happens that other meetings are planned at the same time (Ban3; Observation 4). Furthermore, there is a clear lack of leadership. Although the DAC and DHO think that they share the responsibility of taking the lead, other stakeholders miss the presence of leadership. This perceived lack of leadership effects also the level of participation of NGOs and policy sectors. The policy sectors are primarily weakly involved in the HIV/AIDS control, and therefore they do not contribute as expected. This lack of contribution might be the result of the large number of replacements within the policy offices. All respondents noticed many changes of position within the policy offices, with the consequence that the meetings always need an introduction about HIV in general, despite that a more profound discussion is needed (Ban1; Ban2; Ban3). The quarterly meeting is now primarily dominated by presentations. Bandung's HIV/AIDS strategy is created by the DAC alone, without any input from other sectors (DAC Bandung, 2014). Therefore, the entire HIV/AIDS response is strongly controlled by international and national organizations. There are also some challenges that arise in the information system. Although DHO gathers a centralized dataset, it is hard for other stakeholders to access it. Consequently, other stakeholders cannot use the available information in their own HIV/AIDS programs. Neither sanctions nor rewards are used often, although stakeholders prefer to receive something for their good results (Ban3). Another important problem in

Bandung is the great need to provide compensation, as otherwise people are not motivated enough to attend meetings. Despite the organized meetings, some stakeholders still have no clue how they can contribute. Due to the lack of understanding, most of the stakeholders do not give a high priority to the HIV/AIDS issue. Bandung has still not reached a unified vision, with the consequence that the outcomes are still disappointing (Ban1; Ban3).

6.3 Cirebon

Cirebon is considered a middle-performer in this research. Cirebon possess only a small amount of resources, but its outcomes are relatively good. In 2014, Cirebon had not yet reached a unified vision yet, although all stakeholders are highly motivated (P.C.: Maharani, 2015; Ristya Rahmani, 2015, pp. 10–11). This section considers the action situations in Cirebon to investigate how cooperation is proceeding nowadays.

6.3.1 Meetings in the HIV/AIDS control

Cirebon has several meetings with different stakeholders. The quarterly meeting is in Cirebon also considered as the most important meeting. In this meeting, the three main pillars, policy sectors, the Kesra and private companies are present. The headlines of the programs are discussed, important decisions are made and follow-up plans are formed. Intensive communication takes places between the quarterly meetings. The DAC and DHO are located in the same building, which makes communication a daily occurrence. Consequently, the planning of the meetings is well-defined and clear for all stakeholders. Stakeholders in Cirebon have created an informal setting (Observation 7). All respondents indicate that informal contact is one of the main reasons that the cooperation is successful. *"We meet in the swimming pool, I mean fishing pond, while smoking and having a picnic together. This create emotional ties,"* explained one interviewee (Cir4). This informal context fosters communication, said another: *"So most of the NGO members are more comfortable in informal discussions. They don't really like formal meetings so they express themselves during informal meetings"* (Cir3). Informal meetings create opportunities for stakeholders to simplify discussion during formal meetings said one: *"Yes, it is to simplify, so that we are on the same ground. The most important thing is to decrease refusal. The informal meetings make our discussion topics acceptable for us"* (Cir3).

6.3.2 Actors and boundary rules

The DAC, DHO and NGOs are the stakeholders who contribute the most to HIV response. Additionally, the following policy sectors are also involved: social office, transportation office and labor office (DAC Cirebon, 2015, p. 3). The Kesra is another remarkable contributor, as Cirebon is the only district who involves them. Kesra is the social welfare office at the highest level, with more privileges than normal policy offices. A Kesra representative explained, *"The involvement of our*

office depends on the person. As with me, the social concern should be highlighted by a higher authority. We are always present" (Cir4). Due to the involvement of this higher authority, the DAC and DHO have obtained more possibilities as regards budget allocation and regulations. Furthermore, two private companies are involved as sponsors of activities in certain programs. Still, said one interviewee, *"I think in the districts the private sectors' involvement is not ideal yet"* (Cir3). Other government levels also influence on the quarterly meeting, but this influence is restricted to providing guidelines and other regulations. International, national, and provincial partners do not all attend meetings in Cirebon. Consequently, the relationship with the NAC and PAC is one-sided. The meetings of the NAC and PAC are always attended by local stakeholders of Cirebon, while locally organized meetings are never attended by higher government levels (Cir1). The NGO gives the geographical situation as the reason for the absence of the NAC and PAC; Cirebon district is hard to reach, as it takes at least two days by car (Cir4).

6.3.3 Positions and position rules

Cirebon has established a multi-sectoral response as a result of a wide range of involved stakeholders. However, the question arises of which positons these stakeholders take. The lead is clearly taken by the DHO in Cirebon. The DHO received a new department head in 2010, who has given a high priority to HIV. One DHO representative summarized, *"A year after Mr. Nanang participated you could already feel a change, because a system was starting to be built"* (Cir3). The new head of the department has taken the lead in the entire response with the result that more stakeholders feel compelled to be actively involved. This well-regarded man has been working on the relationship between actors for many years. Several respondents expressed their gratitude to Mr. Nanang. Whereas the three main pillars are actively involved, the policy sectors are still considered as outsiders. A limited number of policy sectors do attend meetings, but their input was still considered by the interviewees to be too little. This view might be the result of the high number of replacements in these offices. *"People who had a good response got replaced,"* pointed out one respondent, adding, *"That's just how it is among the civil servants. So sometimes we want to do this, but we have to step back, step back and repeat and repeat"* (Cir1).

6.3.4 Actions and choice rules

The next set of rules provides insight into what stakeholders actually do with the possibilities of attending the meeting. Formal meetings in Cirebon are also primarily organized to inform stakeholders about the current status of the programs, but the DAC and DHO both indicated a preference also to receive some input (Cir1; Cir2). However, *"Outside the discussion forum they are quite active in giving suggestions, but to attend the formal meeting, they are reluctant. I also do not know why they do so"* (Cir1). The participation level in formal meetings was still considered less than adequate. However, it is informal communication that contributes to the network of stakeholders. The headlines

of the entire HIV/AIDS control are also decided during these informal meetings. Therefore, the formal meetings are primarily used for presentations, whereas the informal meetings function for decision making. As result of the good informal relationship, evaluation is a continuous process. It is especially the information from the NGOs about the key populations that helps to evaluate current HIV/AIDS control. Again, this information is gathered during informal meetings, which means that the formal meetings are mainly used for presentations (Cir1; Cir2; Cir3).

6.3.5 Control and aggregation rules

In Cirebon stakeholders from outside the action situation also strongly influence meetings. The NAC, for example, created national action plans that needs to be incorporated to local regulations and activities. "There is guidance given from the national government which we have to discuss during meetings because it needs to be adopted to our system," explained the head of the DHO (Cir2). The national government is undoubtedly recognized as controller by all local stakeholders. Cirebon does not think that they are able to deliver input on the national level, though. The relationship is one-sided, since nationals never come to Cirebon. Local stakeholders in Cirebon agreed with the PAC program manager, as the PAC's role is mainly providing guidelines (Pro1; Cir2). These guidelines are almost all represented in Cirebon's response, but the DAC emphasizes the broad characteristics of these guidelines. Cirebon identifies the PAC's strategy to create broad frameworks that need to be translated to their own context-specific situation (Cir1; Cir2). Cirebon takes their autonomy to fill in the strategic plans created on higher levels. Thus, there is a clear control of other stakeholders visible in the local action situation, but within this control stakeholders still search for opportunities.

6.3.6 Information and information rules

Data sharing among stakeholders is effective in Cirebon. The DHO and DAC are located in the same building, and the NGO is always welcome to join them. Due to this characteristic openness, stakeholders do not have difficulty assessing the database. The data is centralized by the DHO in one program. *"We all agreed that the data should be accessed through one door and that is the DHO,"* said the DAC (Cir1). However, the data can also be accessed by the DAC and NGOs, according to another: *"All our data is centralized. If the DAC wants it, we give it to them. If the NGO's want it, we also give it to them"* (Cir2). The DHO has the obligation to share the information with other actors, but these stakeholders can also proactively ask the DHO. Since there is a high level of trust among stakeholders, everyone is convinced that the content of the data is reliable. All policies and programs are based on this database, and therefore there are no differences visible in the data. The information sharing is also, as result of good cooperation, not scheduled and is restricted to meetings. During these meetings, the data is shown in order to be sure that everyone understands the actual situation. But besides the organized meetings, stakeholders can also access the data in case they need it. *"Information sharing is not scheduled, but it is open anytime as it depends on the need,"* explained the

DAC (Cir1). Consequently, information is not only shared by official channels, but it can also be accessed by telephone, e-mail or face-to-face (Cir2). Furthermore, the most relevant stakeholders have received the username and passwords to enter the online database directly. The stakeholders in Cirebon do all see the necessity of sharing data, as they all use it to improve their own actions. As the NGO reported, *"Without information about the epidemic, it is not useful to make HIV/AIDS programs, and therefore, we should benefit from it"* (Cir3).

6.3.7 Payoff rules

Sanctions are not favored by all respondents. Although some policy sectors are still not ideally involved, interviewees agreed that sanctions will effect the outcomes even more negatively (Cir1;Cir2;Cir3). However, the program manager of the DAC does use some sanctions in the form of instructions and supervision. The local government can decide, after a warning from the DAC, to give more direct instructions to the policy sectors. Policy sectors can experience this direction as sanction, since they lose some autonomy as a result. As well, respondents in Cirebon do all recognize the importance of granting rewards to good performers. According to the head of the DHO, the health department already uses social and material rewards*: "We show our appreciation by openly involving them at a high level, and we have those kinds of certificates for good performers"* (Cir2). It helps to stimulate and motivate local health centers and other stakeholders. This issue is still controversial for some stakeholders, and therefore civil servants need some incentives (Cir1). Cirebon also offers compensation for stakeholders who attend meetings. Due to the enormity of this district, several stakeholders have to travel for many hours to attend meetings. Since the DAC and DHO want the contribution in meetings, they offer compensation to these stakeholders to be sure that they will attend (Cir1).

6.3.8 Potential outcomes and scope rules

Two years ago stakeholders were working to reach a unified vision and to increase the level of trust among each other. Due to the fact that the DAC and DHO wrote together the strategic plan of Cirebon, both stakeholders have clarity about their positions, functions and tasks (DAC Cirebon, 2015, p. 3). The tolerant attitude towards the NGOs means that these partners also know exactly how they can contribute. The clarity among the policy sectors from outside the health sector is more dubious. Other offices are all less involved in the entire HIV/AIDS problem, and therefore they do not always know how to work on this issue. The lack of clarity for certain stakeholders also effects prioritization. The DAC and DHO work constantly on this issue, the DHO said: *"I prioritize this because I think HIV should be in focus because the case numbers keep increasing"* (Cir2). The policy sectors, on the contrary, feel less the need to work on it. *"For people who work in HIV, I think it is prioritized, but for people who are a bit further away, it is not,"* stated the DAC (Cir1). This difference of priorities is also the main reason that stakeholders in Cirebon still feel that they are missing a unified vision.

"Even now, there is no unified vision. Not everything is working ideally" (Cir1). Although the three main stakeholders are satisfied by their cooperation, the role of the other policy sectors is more dubious. Thus, there is a unified vision among the three stakeholders, but the contribution of other policy sectors is still missing.

6.3.9 Précis

Cirebon has built up a strong relationship among the three main stakeholders. They have intensive contact in both formal and informal meetings. The informal meetings contribute especially to the strong collaboration they experience. The most controversial themes in the HIV response are already discussed before formal meetings, which makes it easier for others to participate (Cir1). Several policy sectors, the Kesra and two private companies are also involved. Cirebon has, with the head of the DHO department, a strong leader in HIV response. Consequently, this leader has created a setting in which stakeholders are willing to contribute (Cir1; Cir3). The DAC and NGOs are, in particular, the two stakeholders who became more involved as result of strong leadership. Nevertheless, the policy sectors are still a bit behind in terms of participation. This lag might be the result of the large number of replacements in the offices. Policy offices often send different people to meetings, with the result that they are not involved enough to participate actively (Cir1; Cir2). The participation during formal meetings is limited since the meeting is primarily used to give presentations. Discussion among stakeholders is possible, but it is restricted to the informal meetings. The information system is well established in Cirebon. The DHO gathers a centralized database that is easily accessible for others. Consequently, stakeholders can generate HIV programs that fit the current epidemiological situation. Respondents in Cirebon are not in favor of sanctions, but rewards are encouraged to increase people's motivation. Compensation is also explicitly needed, as otherwise people are not willing to travel all the way to the city hall (Cir1). Although Cirebon has improved much in recent years, stakeholders still think that a unified vision is not yet been achieved. The three main stakeholders have all have a clear sense of how they can contribute to solving the problem, but the policy sectors are still somewhat behind.

6.4 Bogor

The final case, Bogor, is considered best performer for HIV/AIDS in West Java. It was two years ago that stakeholders in Bogor shared a unified vision, and therefore, this district is used as an example of a well-functioning LKB program.

6.4.1 Meetings in the HIV/AIDS control

Stakeholders in Bogor organize many different meetings in which different people are represented. However, the quarterly meeting is considered the most important meeting, since all relevant stakeholders are present: as one interviewee called it *"very beneficial, very beneficial"* (Bog3). This

meeting helps to set the direction for the entire response, create possibilities for decision-making and evaluate previous actions at the same time. Bogor's HIV/AIDS strategy is created, presented and discussed during this meeting. It is organized quarterly, as proposed in GF programs. However, in the interim, stakeholders also gather to discuss the HIV programs more specifically, as the quarterly meetings only set the direction for the entire response. The tone in Bogor is, in general, informal, with on interviewee's response typifying the feeling that *"we do not have to be too strict. Relaxed. Like that"* (Bog1). However, all stakeholders prefer to organize meetings more formally. It would not be fair, they think, to discuss topics in informal sphere, as such a discussion might exclude other stakeholders (Bog3; Bog4). Nevertheless, informal contact is not unimportant. It contributes to a better understanding and a higher level of trust among stakeholders, as more people feel engaged with the topic (Bog2).

6.4.2 Actors and boundary rules

The DAC, DHO and NGOs are the stakeholders who contribute the most to HIV response. Additionally, the following policy sectors are involved: health office, social office, family planning bureau and labor office (DAC Bogor, 2015, p. 3). The role of Bogor's mayor was highlighted in all interviews, since his involvement is highly appreciated. The mayor is in the position to raise awareness about HIV/AIDS in citizens and government officials. *"The current mayor is strongly involved, because the day after he was inaugurated, he invited me to meet him to talk about HIV and about the HIV situation in Bogor city"* (Bog3). The current mayor is the head of the DAC, with the consequence that many actions related to budget and regulation can be implemented more rapidly. Bogor really attempts to involve as many relevant stakeholders as possible. *"We do not involve only the government. We also involve the NGOs intensively. I also invited the businessmen. I even invited celebrities, as well, to speak about HIV in Bogor"* (Bog3). Consequently, Bogor has established an HIV response in which many multi-sectoral stakeholders are involved.

Local-level respondents in Bogor also recognize the involvement of other government levels. The head of the DHO in Bogor gives as reason that Bogor is frequently used as example of a successful HIV/AIDS response. National and provincial governments would like to learn from the success of Bogor in order to improve their strategic plans (Bog2). Bogor is, for example, the only district in West Java that has established a mutual relationship between local, provincial and national level (Pro1;Pro2). Meetings on local level are regularly attended by members of the NAC and PAC, and local governors also get the opportunity to give input on the national programs (Bog1; Bog2).

6.4.3 Positions and position rules

Leadership of the entire response is clearly visible in Bogor. The head of the DHO department and the secretary of the DAC have been involved for many years. Both stakeholders know each other very

well, with the result that they intervene in both offices. *"The first time I participated was in 1999. Since then I have held a position in the DAC, and I have also held a position in the health office"* (Bog3). However, all stakeholders consider the mayor of Bogor to be the most influential person. He is the one who can give attention to HIV with the consequence that officials are more likely to work on this issue. While it is understood that the mayor, the head of DHO and the DAC secretary should take the lead in the entire response, the meetings are chaired by different people. *"Program manager of the DHO should lead the HIV control effort in general. But in meetings it depends on who organized it,"* explained by the DHO (Bog4). The DHO thinks that changing the position of chair will increase involvement. Being a chairperson is an important position in Indonesian culture, and therefore people take the position very seriously, which prevents laziness. The laid back attitude of policy sectors might be the result of the many changes of position. According to all respondents, sending different people to meetings is one of the biggest problems in coordination. As the NGO summed*, "For the first month A was sent. We agreed on a concept, okay, this is what we are going to do in the future. But the next three months a different person attended, and automatically you get, 'I don't know what happened.' And you must start again"* (Bog6).

6.4.4 Actions and choice rules

The quarterly meeting in Bogor is always structured by a well-defined and previously announced agenda. The meeting includes both presentations and a discussion, the NGO explained: *"We presented, and stakeholders presented, and then we discussed, that is for us how we organize the quarterly meeting"* (Bog4). Presentations are seen as a useful method to motivate stakeholders to do more (Bog4). However, the presentations are always followed by a discussion, as it is the only method to get input from other relevant parties (Bog2). Nevertheless, the topic on the agenda determines whether the inputs gathered during the discussion also influence the decisions. For determining topic, said the DAC, "*It depends on what we are discussing. Sometimes the follow-up steps have been prepared at the start of the meeting, and then you only get input for the others. But other times you start the discussion to solve problems"* (Bog1). The NGOs do also recognize the advantages of this structure of the meetings. *"Usually we discussed to find the middle solution,"* said another. (Bog5). The evaluation is primarily done by the DAC by an official research project. However, they do thoroughly understand the relevance of receiving input from field workers. Therefore, several meetings have also been organized to discuss and evaluate current HIV/AIDS control (Bog1; Bog2).

6.4.5 Control and aggregation rules

Stakeholders in Bogor are also aware of the fact that higher-level authorities try to steer the local action situations with regulations. Said the DAC, *"There are some top down programs that we must implement, so they want to make sure that they are involved with our programs on local scale"* (Bog1). However, the local stakeholders do not experience this control from higher levels as negative.

The positive outcomes of Bogor create also possibilities to deliver input to these levels of higher control. Local stakeholders consider it as a mutually beneficial relationship in which everyone can learn from each other.

6.4.6 Information and information rules

Stakeholders in Bogor are satisfied about information sharing. The DHO is also in this district responsible for the collection of data from local health centers and fieldworkers. The data is collected in one digital database that is available to the DAC and NGOs. The DHO understands the obligation to share data, and therefore it is not difficult for the DAC and NGO to access it. The respondent of the NGO represented the situation as follows: *"It is very easy to get the data from the offices. They are open for anything. Go ahead they said!"* (Bog6). However, in contrast to Bandung and Cirebon, the DAC also delivers input on the data. The DAC is strongly connected to the key populations, with the result that they can also add data to the system. The content of the information is not a point of discussion during meetings. All stakeholders believe that the information is reliable, and therefore data validation is not necessary. *"We just trust it,"* said the DAC (Bog1). The information is shared by different channels. Besides the meetings in which a summary is given about the actual situation, stakeholders receive regular updates about changes in the epidemic. *"When there are some remarkable changes visible in our data system, we think it is useful for other stakeholders to be informed about this,"* said a DHO interviewee (Bog3). Although data sharing is primarily done by face-to-face contact, it is also possible to make phone calls or to send e-mails. However, the DHO still wants central control of the online database, and therefore the DAC and DHO do not have direct access to the system. The update system creates the assumption that stakeholders also use the provided information. Stakeholders see the necessity of context-specific HIV/AIDS programs, and therefore information about the actual situation is very important (Bog7).

6.4.7 Payoff rules

In contrast to Bandung and Cirebon, the respondents of Bogor do not see the necessity of imposing rewards. Indeed, Bogor uses social sanctions for stakeholders who do not reach their targets. The DHO illustrated, *"When the achievement is far from target, we will send a personal message to the staff and the head of the local health service"* (Bog4). Social sanctions are needed to increase motivation and to remind the health offices about the programs. The DAC and DHO both think that appreciation is not required for high-performance actors. Also, without any kind of reward, the outcomes of Bogor are already relatively good. *"We don't give them certain types of appreciation, because you can say that we already work together without it,"* the DAC put it (Bog1). The NGO confirmed the absence of rewards; however, they do assume that providing rewards will result in better outcomes. *"Of course we want to be appreciated. It doesn't have to be formal, maybe just in the form of a certificate,"* said one respondent of a NGO (Bog5; Bog6). Furthermore, Bogor is the only district that does not have to

compensate the stakeholders for attending meetings: *"Even without transport money and other compensations, we still have a meeting with a lot of people,"* one stakeholder observed (Bog3). Nevertheless, providing an excellent lunch is essential (Observation 8).

6.4.8 Potential outcomes and scope rules

The outcomes for Bogor are relatively positive. Although the number of HIV cases per 10,000 people is still quite high, many people have been tested as result of full coverage of HIV/AIDS services in the health centers. Bogor is also the only district with a very strongly unified vision and a high level of trust among stakeholders. Due to the fact that Bogor two years reached this unified vision, stakeholders have in general a good understanding of their positions, functions and tasks. All involved actors work together on the strategy plan by giving input based on their own perspectives. The three main partners in the HIV response and all relevant policy sectors contribute to the strategy plan with the result that everyone can implement their own ideas. The strategy plan is seen as an agreement between all partners that must be followed by everyone (DAC Bogor, 2015, p. 3). *"Every meeting we make again an agreement that everyone has to adhere to. All government institutions need to do that"* expounded the DHO interviewee (Bog4). This view suggests also that all partners clearly understand what is expected from them, since otherwise such agreements would not be made. The unified action plan might be the result of the high priority that stakeholders give to the issue of HIV. *"Yes in Bogor it is a very high priority,"* confirmed one respondent, saying as well, *"We motivate everyone to work more, more and more"* (Bog4). In contrast to the other cases, it is not only the DAC, DHO and NGOs that give a high priority to this issue. The other government policy sectors also understand that their contributions are needed. *"They are also concerned about it. They show the same level of concern as us, as they have seen HIV as an important matter,"* the DHO reflected (Bog4). Due to the high priority of all stakeholders, the unified vision is still observable in Bogor, as is evidenced in one interviewees response: *"Everyone is willing to improve Bogor. We want to make Bogor better. Our vision is one"* (Bog3).

6.4.9 Précis

Bogor still has a good relationship among stakeholders for HIV/AIDS control. The setting of the meetings are primarily formal, as it contributes to fair and open collaboration. Due to the background of the main stakeholders, Bogor has created strong leadership and strongly unified vision. The DAC, DHO and the NGOs have worked together with several policy sectors to create a multi-sectoral response. Moreover, it is the involvement of the mayor that makes the response in Bogor quite unique (Bog3). The mayor is concerned about this issue with the consequence that he attempts to increase awareness among authorities and citizens. Although Bogor has some strong leaders, during meetings they try to change positions, as this habit helps to get everyone more involved (Bog1). Different people need to organize meetings in order to keep everyone working on this issue. Nevertheless, the

policy sectors are still a bit behind in their participation. This familiar lag from this sector might by the result of the large number of replacements in the offices. As in other areas, policy offices often send different people to the meetings, with the result that they are not familiar enough with the topic to join the discussion (Bog1; Bog2; Bog3; Bog5). The DHO collects all data in a centralized database that can be accessed by stakeholders. Interested stakeholders can contact the DHO, and afterward they can receive information through several channels. Sanctions, rewards and compensations are in general not favored by stakeholders. In Bogor, people also attend meetings without any reward or compensation, because they all understand that something needs to be done against HIV. Therefore, the conclusion can also be drawn that Bogor maintains its unified vision as a result of a high priority given by stakeholders. All people working on HIV clearly understand how they can contribute to this issue.

6.5 Cross-sectional analysis

The action situations in the three districts are extensively described and summarized in Table 10. All districts prefer to establish a multi-sectoral response, as they all admit that the HIV/AIDS problem cannot be solved by a solo stakeholder. In order to organize such a response, meetings need to be organized to establish collaboration between stakeholders. Previous research has shown that stakeholders in Bandung are not working well together, whereas stakeholders in Cirebon and Bogor collaborate better (Ristya Rahmani, 2015, pp. 17–18). The description of the action situations and the institutional rules help to investigate the features for a successful cooperation.

Overview of the action situations and the rules in use in the three districts

Variable	Dimension	Bandung	Cirebon	Bogor
Action situation	Kind of meetings	Quarterly meetings with at least the DAC, DHO and NGOS	Quarterly meetings with at least the DAC, DHO, NGOs and some policy sectors. Many different informal meetings in between.	Quarterly meetings about the broad proposals and many other meetings about specific program.
	Number of meetings	Once in the three months	One in the three months an official meeting, but many informal meetings in between.	Quarterly meeting once in the three months and many other meetings in between.
	Planning	Unclear and double planned	Clear and organized	Clear and organized
	Setting	Formal	Informal and formal	Formal
Boundary rules	Involvement three main stakeholders	Yes strongly involved	Yes strongly involved	Yes strongly involved
	Involvement other government officials	Health office, social office, education office, youth & sports office and family planning bureau	Health office, social office, transportation office, labor office and Kesra	Health office, social office, family planning bureau and labor office
	Private sector	Unknown	Two companies	Several companies
Position rules	Leadership	DAC or DHO, but the NGOs and policy sectors do not recognize this position.	DHO	DAC, DHO and mayor
	Participants	NGOs	DAC and NGOs	NGOs and policy sectors

	Audience	Policy sectors	Policy sectors	-
	Changes in representative people	Extremely high number of replacements	High number of replacements only in the policy offices	High number of replacements only in the policy offices
Choice rules	Presentations	During the entire meeting.	During the entire meeting	Part of the meeting
	Discussion	Not possible	Possible, but only during informal meetings	Essential for all stakeholders
	Evaluation	Evaluation done by the DAC	Possible by having informal contact	Evaluation done by the DAC with input of others
	Decision-making	Decisions are made by the DAC or DHO without any input	Decisions are made based on input from informal meetings	Decisions are made based on input
Aggregation rules	Control of other authorities by given regulations	Yes, primarily international regulations established by Global Fund	Yes, but policy freedom is recognized and used to adopt it to their own epidemical situation	Yes, but they only use it as their starting point
	Control of authorities by entering the action situation	Rarely	Rarely	Often since higher authorities use Bogor as example
Information rules	Centralized data base	Yes, collected by the DHO	Yes, collected by the DHO	Yes, collected by the DHO
	Obligation to share this date base	No, hard to get for other stakeholders	Yes, it is easy to access for all stakeholders.	Yes, it is possible to request the DHO to consult the data
	Methods of sharing this data base	Primary by presentations and rarely by e-mail	All possible ways: face-to-face, e-mail, phone, presentations etc.	Primarily by e-mail and presentations
	Use data base by stakeholders	No, received information too late	Yes	Yes
Pay off rules	Sanctions	Rarely social sanctions	No	No
	Rewards	Working to provide certifications	Yes	No, but the NGOs desire
	Compensation of the costs	Highly needed	Needed due to the far distance stakeholders need to travel to join a meeting	No, even without compensation stakeholders attend meetings
Scope rules	Clearness HIV/AIDS programs	Clear for the DAC and DHO, but not for other stakeholders	Clear for the DAC, DHO and NGOs, but not for all other policy sectors	Clear for all stakeholders
	Given priority to implement the programs	Priority for the DAC and DHO, but not for the other stakeholders.	Priority for the DAC, DHO and NGOs, but not for all other policy sectors	Priority for all stakeholders
	Unified vision	No	Almost	Yes

Table 10: An overview of the action situations and the institutional rules in the three districts.

Based on the table above, a comparison of the districts can be made in order to understand the institutional diversity among them. Furthermore, this comparison helps to discover the conditions of successful collaboration within the LKB program.

Meetings. Stakeholders in all three districts admit that meetings need to be organized to start the collaboration. The quarterly meeting is considered the most important meeting, as it includes all relevant stakeholders and it gives the possibility for setting direction for the entire HIV response.

Respondents are satisfied with the frequency of once every three months. However, particularly Cirebon attached a strong value to the organization of informal meetings outside of the formal meetings. Not all stakeholders feel confident to express themselves during meetings, and a good relationship created in an informal setting contributes to increasing that confidence. Bogor acknowledges the contribution of informal meetings, but emphasizes that these meetings should be used only to create better relationships. Important decisions must always be made during formal meetings to prevent that stakeholders from feeling excluded from the topic.

Boundary rules. The boundary rules provided insight into the involvement of certain stakeholders. In all three districts, the DAC, DHO and NGOs are considered the main contributors to HIV/AIDS control. The involvement of other policy sectors, on the contrary, is highly diverse, as districts are free to invite them. Although the involvement level of the policy sectors in Bandung is doubtful, it is especially this district that has several concerned policy sectors. In Cirebon and Bogor, private companies are also involved, although their involvement is limited to the distribution of resources. Besides multi-sectoral partners, multi-level relations are also established in all three districts. Higher-level authorities are concerned with the local HIV/AIDS control, and therefore the WHO and UNAIDS provide, for example, extra resources. The involvement of the NAC and PAC varies by district. Whereas the input of these commissions is limited to providing resources and guidelines in Bandung and Cirebon, Bogor's meetings are also directly attended.

Position rules. Stakeholders in Cirebon and Bogor have a preference for strong leader, as such leadership helps to fix appointments and to increase awareness about the issue. Policy sectors often have the feeling that HIV/AIDS does not belong among their main tasks, with the consequence that some of the arrangements are never completed. Bandung, in particular, demonstrates a clear absence of strong leadership, as the position of leader has changed many times. Cirebon and Bogor both have a strong leader with much experience and concern about HIV/AIDS. Furthermore, both districts attempt to involve higher authorities, as such involvement helps to increase awareness among citizens. Whereas Cirebon has the involvement of the Kesra, Bogor is even a step further, with the active participation of the mayor. The change of positions is a problem faced by all districts, specifically in regard to policy offices, what have many times sent different people to the meetings, with the result that meetings reiterate the context of previous meetings.

Choice rules. Presentations are an essential part of meetings in all districts of West Java. They help to inform all stakeholders about current HIV/AIDS control, and they foster greater motivation. Although all stakeholders prefer to continue the presentation with a discussion, such continuation is possible only in Bogor. Stakeholders in Cirebon are not confident to express themselves during formal meetings, and consequently, impactful discussion happens only during informal contact. Only in

Bogor is decision-making part of the meeting. In both Bandung and Cirebon, decisions are already made before the meeting. Evaluation is another essential part of HIV/AIDS control, but this task is also not always part of the action during the meetings. Although NGOs and field workers are closely connected with the key populations, it is hard for them to deliver input in meetings in Bandung and Cirebon.

Information rules. The three districts have all created a centralized database in which the status of the current HIV/AIDS epidemic is registered. However, the districts differ in the openness of this database. Although Bandung's DHO claims to have an open system, other stakeholders have problems receiving information. Cirebon demonstrates notable openness in information sharing. Stakeholders in Cirebon do see the necessity of sharing data in advance, as it helps to improve HIV/AIDS activities. Bogor is, again, more formal in the exchange of information, but a request for data is most of the time accepted, since they also see information sharing as essential.

Payoff rules. Districts are, in general, not in favor of imposing sanctions for weak performance. However, Bandung is the only district that sometimes uses social sanctions to be sure that policy offices comply with the agreements. Rewards, by contrast, are in general appreciated by all stakeholders. Simple rewards, such as certificates and announcements, can help to motivate and stimulate stakeholders. In addition, Bandung and Cirebon both need compensate people who attend meetings. Bogor, however, has shown that this compensation is needed only in the case of stakeholders who do not see the urgency of action regarding HIV/AIDS control.

Scope rules. Clarity about the LKB program and priority given to this issue are both essential to working effectively. Stakeholders in Bandung are still not familiar with the LKB program, with the consequence that they are less motivated to work on it. Cirebon has been working hard to reach a unified vision, but the three main stakeholders are still in complete agreement. As well, some policy sectors are still behind in the level of participation as result of a lack of understanding. Bogor, on the contrary, achieved a unified vision in 2014. Stakeholders are all highly motivated, and they all clearly understand how they can contribute in the LKB program.

6.6 What to learn from these differences?

The three institutional analyses function also as foundation for recommendations that help to give more direction to the LKB program. The interviews asked what stakeholders think needs to be improved. The table below shows the conditions mentioned by certain respondents as recommendations. Several conditions were mentioned by all twenty respondents. The informal setting, sanctions and compensation are the only recommendations that were not mentioned by all respondents. Moreover, in Bandung, the stakeholders do not see the necessity of having a strong leader

and involving higher authorities. It might be the result of the lack of experience with it, but it can also be that it does not fit with their organizational setting. There are also five other recommendations proposed by stakeholders that do not directly fit within the theoretical framework.

Overview of recommendations mentioned by respondents

Recommendations	**Mentioned by**
Creating an informal and formal setting	All respondents in Cirebon. Bog1;Bog2;Bog4
Having a strong leader	All respondents in Cirebon and Bogor
Involving higher authorities	All respondents in Cirebon and Bogor
Avoiding changes in positions	All respondents in Bandung, Cirebon and Bogor
Starting a discussion	All respondents in Bandung, Cirebon and Bogor
Taking decisions together	All respondents in Cirebon and Bogor
Centralized data base	All respondents in Bandung, Cirebon and Bogor
Open access for relevant stakeholders	All respondents in Bandung, Cirebon and Bogor
Imposing sanctions	Ban2;Bog3;Bog4
Giving rewards	All respondents in Bandung and Cirebon. Bog5;Bog6;Bog7
Using compensation systems	*Ban2;Ban3;Cir1;Cir2;Cir3*
Getting more involved with the field work	*Bog5;Bog6*
Creating stricter follow-up plans	*Ban2*
Possessing more resources	*Ban2;Cir1;Cir2;Bog3;Bog4*
Doing more advocacy to policy offices	*Ban1*
Doing more research to increase knowledge	*Bog1*

Table 11: An overview of recommendations derived from the interviews. The Italic recommendations are inductive derived.

6.7 Conclusion

This chapter detailed the action situations in which stakeholders work together to produce joint outcomes. All three districts encounter problems with the involvement of stakeholders from outside of the health sector. The priority given to the HIV/AIDS issue in combination with a lack of understanding resulted in weak involvement from these parties. Participation is also limited due to the high number of change in positions. Policy sectors often send new representatives without any previous knowledge of HIV/AIDS or the related programs. However, several conditions were also found that helps to explain the discrepancies in LKB program's effectiveness. Bandung has neither a strong leader nor the involvement of higher authorities. Such leaders contribute positively, as they increase the awareness and motivation of both policy offices and citizens to work in HIV/AIDS. The informal setting is another explanation for the existing differences in the LKB program's effectiveness. An informal setting contributes positively to collaboration, as it creates opportunities for stakeholders to express themselves more freely. Furthermore, all respondents recognize the importance of having a discussion among all parties. In both Bandung and Cirebon, it is hard to start this discussion, meaning that most decisions are not made collaboratively. The lack of openness about information in Bandung is expected to be another barrier to effective collaboration. An assessable

information system contributes to the establishment of context-specific policies. The motivation of stakeholders can be increased by providing rewards instead of sanctions. Indonesian stakeholders need a kind of appreciation for their work to help to strengthen the network of stakeholders within the LKB program.

Chapter 7 – Conclusion

7.1 Introduction

This chapter encompasses the previous chapters in order explain the discrepancies in the LKB program and to discover the governance conditions for successful implementation of this particular program. The conclusion of this research includes several parts. First of all, I will present an answer to the sub-questions (Section 7.2) and the final answer to the research question (Section 7.3). This presentation is followed by a discussion of the theoretical parts of the study in Section 7.4, and the methods in Section 7.5. Since this thesis emphasizes learning from differences, I make some recommendations in Section 7.6. This chapter end the study by discussing possibilities for further research in Section 7.7.

7.2 Answer to the sub-questions

Today's governance trend is to organize global health responses by involving a wide range of stakeholders. The LKB program is that particular program that should strengthen this network of involved parties (Prawiranegara & Tromp, 2015, p. 8). However, due to the decentralized political structure of Indonesia, provinces and districts are able to establish their own responses, resulting in differences in effectiveness among districts. This discrepancy functions as starting point of this thesis. The following research question will be answered based on three sub-questions:

"What explains the large discrepancies in the implementation of the LKB program in the three districts of West Java concerning collaboration among stakeholders, and what are the subsequent conditions for successful collaboration?"

7.2.1 Sub-question 1: What is the current status of the HIV/AIDS epidemic and programs in the world, in Indonesia and on West Java?

In Chapter 2 we noted the exceptionality of the HIV/AIDS epidemic. It became clear that HIV/AIDS is one of the most challenging global health problems, as the number of people living with HIV/AIDS is increasing, while medical treatments are still not assessable for everyone (a. UN, 2015). Although the number of new infections is declining globally, this trend is not true for Indonesia. This country is a cause for concern because the expectation is that the number of new infections will increase tremendously. West Java is one of the provinces with this worrisome picture. New HIV infections and the impact of the virus will be disastrous in this province unless the government implements effective interventions (NAC, 2015). Outcomes in most of the districts of West Java are disappointing, as HIV services are not provided in all health centers, and many people have still not been tested. However, some districts are more on track in establishing an effective HIV/AIDS response than other districts.

Nowadays, governance is proposed as the main method to coordinate such a response, in which a wide range of stakeholders need to be involved. The LKB program is that particular framework that might help to strengthen the network of stakeholders (PRISMA, 2015, p. 8). This thesis attempts to provide better direction concerning how this program can be used to improve collaboration in the HIV/AIDS response.

7.2.2 Sub-question 2: What does the literature propose for governing global health issues, and which theories explain the institutional diversity in the HIV/AIDS programs in West Java?

HIV/AIDS issue require collective action among a wide range of stakeholders, as it has become clear that the problem cannot be addressed adequately by individual governments. The WoS paradigm is proposed in Chapter 3 as an answer to this problem, including a wide range of stakeholders in health issues. This approach emphasizes the importance of involving different sectors from state, market and community as part of the same system functioning on multiple scales. It fully embraces the concept of multi-sectoral and multi-level partnerships. Multi-sectoral partnerships are necessary to tackle social, economic, and cultural issues related to HIV. The decentralized structure of Indonesia precipitates the need for multi-level partnerships in which a combination of control and autonomy by polycentrism should be created. The extent of the presence of the WoS approach has been researched with the help of the IAD framework of Elinor Ostrom. This particular framework helped to examine the diverse institutional settings of the three districts of West Java. The external variables provided insight into which collaborations are able to exist. The action situations, the core component of this framework, are meetings in which interactions take place. In this part of the framework, we can observe the visibility of the WoS approach as it includes interactions between a wide range of stakeholders described by institutional rules. Since this research attempts to explain this discrepancy and to discover the conditions for successful implementation of the LKB program, the learning curve is added to the theoretical framework.

7.2.4 Sub-question 3: What institutional settings of collaborations are present in the three different districts of West Java (Bandung, Cirebon and Bogor)?

We found that Bandung has obviously the best economic position, as both the GDP as the HDI are significantly higher than in other districts. Although the availability of resources is also much higher than the average, this availability does not result in better outcomes. Bandung is measured as one of the weak performers in HIV/AIDS response. Stakeholders do not work well together as result of a lack of trust, an absence of common understanding and the passive work style of civil servants. Once in the three months, stakeholders gather to present the current status of the epidemic and to give direction for programs in the future. Although Bandung attempts to establish multi-sectoral and multi-level partnerships, it does not succeed fully. The DAC, DHO and NGO, the three main pillars, criticize each other regarding their competence to organize an integrated response, and consequently stakeholders

work against each other. The policy sectors are also primarily weakly involved, as their input is limited to attending meetings. Due to the chaotic collaboration among the three main pillars, the involvement of higher authorities is also negligible. The function of higher government levels is restricted to providing guidance and helping with advocacy. The expectation would be that Bandung should use its autonomy to establish a local response. However, stakeholders succeed only partially, since the entire response is built on the only DAC. In sum, the collaboration is still weak, with a lack of vision being the result. Several factors are presented as causes: a lack of leadership, a high rate of turnover in policy positions, no time for discussion, a malfunctioning information system and the absence of a reward system. Stakeholders still need to receive a compensation for attending meetings, as the priority of this issue is still not realized.

We learned that Cirebon is a medium-good performer. Compare to the other districts, Cirebon is one of the largest districts in West Java, with the weakest economic situation. Nevertheless, the outcomes of the HIV response are not disappointing as result of the attributes of community. The three main stakeholders in HIV/AIDS response have built strong relationships, both formal and informal. The informal setting, specifically, makes Cirebon an interesting case. We found that the informal meetings contribute explicitly, as they create opportunities to discuss controversial themes beforehand. Participants are, consequently, more likely to participate actively during informal meetings with concrete decisions and appointments as result. Another contributor to the network of stakeholders includes the strong leadership of the DHO. The three main stakeholders are willing to work on HIV/AIDS because the head of the DHO communicates clearly, as a leader, about the current status of the issue. However, the policy sectors and private companies are still somewhat behind in their level of participation, and the involvement of higher authorities is restricted to offering guidelines. The lack of implementing multi-sectoral and multi-level partners might be the result of a high number of changes in positions and the absence of a reward system.

Bogor is always considered as an excellent example in the HIV/AIDS response. We determined that the outcomes for the city of Bogor are obviously the best, as there is a full coverage of HIV services in health centers, causing a high number of people to get tested. Bogor has created a beneficial socio-cultural setting in which stakeholders feel confident to work together. For many years, stakeholders have been working to establish an integrated and effective HIV response. The DAC, DHO and NGO work closely together to involve other policy sectors, private companies and communities. Although the policy sectors still lag in the participation, a multi-sectoral response has been established in Bogor. Furthermore, international organizations, the NAC and the PAC are all highly interested in Bogor's HIV response, so a mutual relationship among government layers exists. Higher authorities use Bogor's response and experience as input for national and provincial plans and Bogor takes the chance to acquire more resources and information. The method of switching leadership positions within the

collaborative effort contributes to increasing awareness about the entire HIV/AIDS response. However, we have also seen that Bogor face challenges with the replacement of civil servants in policy offices. Nevertheless, almost all respondents prioritize the HIV/AIDS issue and clearly understand how they can contribute.

7.3 Answer to the research question

This study endeavored to answer the question of how the discrepancy in the implementation of the LKB program can be explained and, subsequently, aimed to discover the conditions of successful collaboration. Although a previously performed comparative analysis between West Java and Bali created the expectation that a better economic situation and a higher availability of resources contributed to a better LKB program, we found something different in this study. Bandung is in a much better economic position than the two other districts, but the outcomes are not as good as in Bogor or Cirebon. Therefore, it is especially the social and cultural setting of cooperating stakeholders that contributes to effective implementation of the LKB program. The theoretical assumptions of the WoS paradigm seem to be right: collaboration with plural organizations and several institutions from different state levels, market parties and civil society organizations all function in one system helps to combat issues such as HIV/AIDS.

However, the success of the WoS paradigm is highly dependent on local conditions, since the results of the three districts differ so widely. Nevertheless, similarities in the problems of the LKB program's implementation have also been found. All three cases have shown that it is not without effort that many stakeholders in the local Indonesian HIV/AIDS responses become involved. The priority given to this issue by several stakeholders is still too low to make them highly involved during meetings. Primarily due the high number of position changes, policy sectors such as the education office, social office and labor office, private companies and communities attend meetings in all three districts, but their input and contribution to the HIV/AIDS problem is limited.

Although all districts face problems involving stakeholders from outside the health sector, there are also some differences in the method of collaboration that can help to explain the discrepancy of LKB program's functioning. Firstly, districts have differing methods of combining autonomy and control in the multi-level relationship between government levels. Districts are more effective with mutual relationships in which autonomy is taken to adopt policies to the epidemiological context and control is accepted to set a strong policy direction. Secondly, the informal setting in some districts helps to create a stronger network among stakeholders. Thirdly, meetings need to include discussion time to take input from other stakeholders into account for decision-making. Fourthly, the appearance of a strong leader increases the awareness of both citizens and people who work within the LKB program. Fifthly, an assessable information system contributes to the establishment of context-specific policies

and a higher level of trust among stakeholders. Sixthly, providing rewards instead of sanctions contributes to the motivation of those who implement the LKB program.

7.4 Theoretical reflection

Governance, polycentrism and the subsequent WoS paradigm are nowadays frequently used terms, but these concepts have yet to be fully developed. There exists a wide variety of interpretations of "governance," which has caused many scholars to question the value of the concept. The LKB program encourages also a strong network of multi-sectoral and multi-level partnerships. This research, on the contrary, has shown that the local people actually do not really know how to organize this implementation of governance, which provide some justification of the critiques of governance. We admit that governance is still a broad concept, in the process of being defined and understood, and therefore that no perfect definition or implementation has yet arisen. Nevertheless, we do actually see the advantages of having such a broad concept. Today's challenges could not and cannot be faced with the concept of government alone, since technical revolutions, globalization, and economic crises are ongoing. Governance can, due to its involvement of relevant stakeholders, provide the government with new ideas, more input and more opportunities to work more efficiently. In conclusion, it cannot be denied that governance has many concepts that can be applied to almost every policy nowadays. However, in our opinion governance is above all else the answer to global health challenges, which definitely need to incorporate many things into one. Therefore, we fully encourage research on applied governance in several policy domains in order to set further direction.

The IAD framework is chosen as the method to research the institutional setting from many different perspectives. Although it has provided a helpfully broad concept to research the institutional setting in three districts, we would comment on it. Ostrom and her colleagues attached a high value to incorporating the activities of local communities, as collective problems are best supplied on a decentralized level (Andersson & Ostrom, 2008, p. 72). However, local communities in Indonesia are, in general, too weak to respond effectively to HIV/AIDS because of a lack of resources and the absence the will to work on this issue. Therefore, the emphasis on the use of local knowledge needs to be impaired and polycentrism should be embraced in the IAD framework. We further argue that the presence of the learning curve is underestimated in Ostrom's work. The IAD framework is primarily used to describe and explain institutional diversity in a range of contexts, whereas in our opinion learning from these differences is also of much value. Experimentalist governance, with Charles Sabel as founding father, would be an interesting theoretical addition. Sabel and Ostrom both agree on the importance of local circumstances, and EG accommodates diversity in adapting general goals to varied local contexts rather than imposing one-size-fits all solutions (Búrca et al., 2014, p. 2).

In all, the combination of the IAD framework and the WoS approach was, in hindsight, a good choice. Even though they were not flawless methods and not all variables could be operationalized extensively, this study has provided an explanation of why Bandung, Cirebon and Bogor have implemented the LKB differently.

7.5 Methodological reflection

The LKB program was implemented in 11 districts of West Java by the end of 2012 (PRISMA, 2015, p. 8). The early stage of this program makes it tricky to perform an institutional analysis, since the concepts of the entire institution are relatively new for me as well as for the those implementing them.
My methodological choices helped me to research this phenomena from a broad qualitative perspective. It is this broad perspective, in particular, that has contributed to the discovery of the essential conditions to improve the LKB program. Through data triangulation and feedback from several respondents and experts, I am convinced that we have explored the collaboration accurately. Because only three districts out of 27 were researched, though, it may be hard to generalize this study's findings. However, in my opinion studying three districts extensively has provided more in-depth information.

Furthermore, I experienced how difficult it is to conduct research in a context unfamiliar to me. Especially at the start of this thesis, I encountered several difficulties. The institutional setting in Indonesia is much different than in the Netherlands, and consequently it took me quit a long time to get familiar with this topic. The conducted interviews in Bahasa were also not helpful to get closely engaged with stakeholders and their stories. The language barriers are, therefore, also one of the methodological limitations. Experienced translators helped me to overcome this barrier, but I was still highly dependent on other researchers to answer questions and to gather useful documents. Although I have interviewed many different stakeholders, more would always have been better. As result of the large geographical size of West Java in combination of the chaotic work-style of civil servants, it was hard for me to conduct more interviews. Furthermore, the HIV/AIDS issue is an actual subject nowadays, making the programs and related institutions very dynamic. Sometimes I had the feeling that interviews and observations were already outdated when I was still collecting the data.

7.6 Recommendations for better collaboration

This thesis put much emphasize on learning. Whereas the IAD framework helped to explain the differences in collaboration, the learning curve founded on EG helped to learn from this particular institutional diversity. Since it is especially the HIV/AIDS response in West Java that needs improvements, we would like to make some recommendations based on this research and on a previously written scholarly article about West Java and Bali (Damink, 2016). These recommendations can be used to give better direction for the implementation of the LKB program.

- *Multi-sectoral partnerships.* The WoS approach proposed to involve a wide range of stakeholders to tackle the HIV/AIDS problem from different sides. However, we would give priority to a strong relationship between the DAC, DHO and NGO first. Policy sectors such as social, education and tourism office can also contribute, but it became clear that such contribution is hard to arrange. Policy sectors are less motivated to work on HIV/AIDS since they do not consider it a main task. Below, some recommendations are provided to increase the involvement of multi-sectoral partners.
- *Multi-level partnerships*. We want to emphasize the importance of having a combination of control and autonomy in the relationship between government levels. Control is required since all districts face problems in gathering the local HIV/AIDS budget and establishing local regulations. Higher authorities should provide a general set of guidelines and follow-up plans, help and advice districts in case it is needed and attend local meetings regularly. Autonomy should be given by higher authorities, but the districts are also responsible for embracing that autonomy. The NAC and PAC create a general set of outlines, and subsequently districts should take the opportunity to adapt it to the contextual setting. This thesis has shown that the exercise of autonomy is strongly related to the outcomes of a district.
- *Meetings in general*. Regularly meetings are necessary to get all stakeholders involved with HIV/AIDS. However, Indonesian people attach much value to having a good relationship, and therefore informal contact can be used. Although decisions should be made during formal meetings, informal meetings can contribute to making the topic less controversial and to talking more openly about HIV/AIDS.
- *Leadership.* Having a leader can contribute to the involvement of policy sectors and other relevant stakeholders. The priority given to the HIV/AIDS issue is still not high enough in West Java. A mayor, famous public person or another higher authority can help to increase the awareness and solidify appointments.
- *Schedule discussion time*. Current meetings include primarily presentations of people who are familiar with this topic, while discussion and input from the audience is necessary to get people more involved.
- *Avoiding replacements*. Civil servants in policy offices change many times from positions, with the consequence that every meeting is attended by people who are not familiar with the topic. This inconsistency should be avoided.
- *Creating an open information system*. The created centralized data system should be open to all stakeholders who can use it appropriately. Stakeholders should use the data about the epidemiological situation in order to implement a contextualized HIV response.

- *Rewarding system.* Showing appreciation is in Indonesia a very important aspect of the culture. Stakeholders all confirmed that they need a kind of appreciation for their work in the HIV response. Simple rewards, such as certificates, announcements or pens, can help to motivate and stimulate stakeholders.

7.7 Recommendations for further research

Although this research has some limitations, I am convinced that it has contributed much to the theoretical debate about governance in health issues. In the field of biomedical studies, it is quite unique to investigate collaboration among stakeholders during the implementation of health interventions. As this research has shown, governance is very essential to organizing an effective HIV/AIDS response, and therefore I would recommended scientists in the biomedical field to use institutional analysis more often.

Another recommendation fits one of the limitations described in the previous section. Since the LKB program is implemented recently, it is needed to follow the process of collaboration closely. Follow-up research can also be used as a confirmation of this research and therefore can contribute to the theoretical debate as well. Due to practical limitation, I have confined myself to HIV/AIDS in West Java. However, Indonesia is the largest archipelagic country in the world, with great cultural diversity between all islands. As can also be read in the added article in the appendices (Damink, 2016), it might be interesting to include more Indonesian provinces with, for example, another contextual setting. Furthermore, HIV/AIDS has spread to every country in the world, and many other countries face challenges in establishing an effective answer to the epidemic. Therefore, I recommend that this research be internationalized, as HIV/AIDS remains an international global health problem. A first interesting step would be the application of an institutional analysis to the Vietnamese situation. Although the epidemiological expectation in both Indonesia and Vietnam were both worrisome, Vietnam has established a successful response by using the LKB program. This case is even more interesting, as it is completely different from the decentralized government structure in Indonesia (Green, McPherson, Fujita, et al., 2007, p. 25).

Finally, it would be interesting to apply this institutional analysis to other global problems. The world faces many other global issues, all of which need to incorporate a wide range of stakeholders, as no one can solve them on their own. The combination of the WoS approach with the IAD framework of Ostrom creates great insight into necessary governance conditions, and hopefully it could contribute to better collaboration among stakeholders in order to combat disastrous global problems.

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Appendices

APPENDIX I: An overview of the involved stakeholders and their duties at district level

Sector	Institution	Duties
Government Institutions	DAC (District AIDS Commission)	To coordinate the development of policies, strategies and any other steps needed to address the HIV/AIDS epidemic based on national- and provincial guidelines. To lead, organize, control, supervise and evaluate the implementation of the HIV/AIDS control done by others in the districts and cities. To gather, mobilize, provide resources given by national, provincial or foreign organizations. To coordinate meetings among other policy sectors (SKPD). To conduct regional cooperation between different districts. To dissimilate information about the HIV/AIDS control to the general public and other involved organizations. To facilitate sub district and village government to control HIV/AIDS. To encourage development of NGOs and society care programmes on HIV/AIDS. To monitor and evaluate all programs and report this back to provincial and national level (NAC, 2011).
	DHO (District Health Office)	To coordinate all health services established in the district. To organize meetings among all health services in order to be sure that they all implement HIV/AIDS programs (PAC, 2009).
Civil society	NGO (Non-governmental organization)	To promote HIV/AIDS programs. To outreach to the key populations. To represent citizens and especially the key populations. To report about the current status of the HIV/AIDS epidemic.
	WPA (Society Care)	To be the first speaking point to local citizens whom has concerns.
Private actors	CSR (Corporate Social Responsibilities)	To provide money or other resources to the HIV/AIDS epidemic.
International Organizations	WHO	To assess and update HIV/AIDS guidelines. To advocate for and support expansion of new technologies and approached. To advocate for strategic linkages within HIV services and with other programmes and services. To support countries to review and reorganize their programmes (WHO, 2015, pp.13-30).
	UNAIDS	To provide five-years strategy plans. To advocate in countries to implement their plans (UNAIDS, 2016)
	Global Fund	To investing to accelerate the HIV/AIDS epidemic To stimulate locals to provide contextual programmes To build resilient and sustainable systems for health. To stimulate partnerships (GlobalFund, 2016)

APPENDIX II: Standard Interview Protocol (DAC, DHO and NGO on district level)

Interviewer	
Respondent	
District	
Position	
Date of interview	
Location of interview	

Before the interview

- Thank the respondent for his/her time
- Ask permission to record the interview
- Ask about the anonymity
- Let him/her sign the informed consent
- A short introduction of myself
- Ask the person to introduce himself/herself. Following things need to be answered:
    - Organization
    - How long he/she has been working on this issue
- A short introduction to the research
    - Describe the aim of this research
    - Explain why the respondent is relevant to the research
    - Explain the concept and definition of governance

HIV/AIDS epidemic

- How do you describe the HIV epidemic in your district?
- What is your organization doing in the HIV/AIDS response?
- What kind of programs have been set up by your organization?
- What is your opinion about the HIV/AIDS response until now?
- To what extent is it the responsibility of your organization to solve this problem?
- Do you think that HIV/AIDS get enough attention in the government sector?

LKB

- Are you familiar with the LKB program?
- What is, according to you, the main aim of the LKB program?
- What is your responsibility / task within the LKB program?
- Do you think that it is clear what your organization must do within the LKB program?
- How is the process of implementation going until now?
- Have you seen changes after the implementation of the LKB program?

Policy sectors (Questions to DAC)

- Which policy sectors are involved in the HIV/AIDS response?
- How do you communicate towards these policy sectors?
- To what extent do you think that these policy sectors are working well on this issue?
- Do you think that these policy sectors put enough effort in the HIV/AIDS response?

Health departments (Questions to DHO)

- Within the DHO, which departments are involved in the HIV/AIDS response?
- How is the communication going between these different departments?
- Do you think that these departments cooperate well among each other?
- To what extent do you think that these policy sectors are working well on this issue?
- Do you think that these policy sectors put enough effort in the HIV/AIDS response?

NGOs (Questions to NGOs)

- Do you work frequently together with the NGOs?
- How do you describe the relationship among the different NGOs?
- How is the communication going between these NGOs?
- Do you think that these NGOs put enough effort in the HIV/AIDS response?

Three main pillars: DAC, DHO and NGO

- How do you describe the relationship between DAC, DHO and NGOs (three pillars)?
- How do you attempt to facilitate this relationship?
- Can you tell me something about meetings between these three pillars?
    - With who do you meet?
    - Why is there chosen to involve these stakeholders?
    - How often do you meet?
    - How do you describe these meetings?
    - What is the main purpose of the meetings?
    - Are always the same stakeholders represented?

Position rules

- What is your position during these meetings?
- Who do you think should take the leadership in these meetings?
- What is the role of the other people who attend these meetings?

Choice rules

- To what extent do you think that these meetings are useful?
- What kind of results do you get after a meeting?
- Can you describe the setting of these meetings? Is it formal or informal organized?
- How was the discussion among the stakeholders?
- Are there some stakeholders with more power than other stakeholders?
- Are there stakeholders who can influence the agenda setting process?

Aggregation rules

- How do you make decisions during meetings?
- Do you have regulations about who has to make the decisions?
- Are there people who control the process of the LKB?
- Are there people from outside that can control the whole situation? (National or Provincial?)

Information rules

- Do you have the duty to share information to other stakeholders?
- How is the information distributing going between the involved stakeholders?
- Do all the stakeholders use the same information?
- Do you think that stakeholders use the received information to establish policies?
- What are the used communication methods between the stakeholders?

Payoff rules

- Are there any sanctions that can be imposed for stakeholders whom are not following the requirements?
- Are there any positive rewards offered to participants whom function well?
- Do you think that these sanctions and rewards influence the participation of the stakeholders?

Scope rules

- Do you think that all the stakeholders see the problem of the epidemic?
- Do you think that everyone put the same amount of effort in solving the problem?
- Do you think that you all agree on this main aim of the LKB?
- Do you think that it is clear for everyone what they have to do in the LKB program?

Attributes of community

- To what extent do you feel confident to work together with the other stakeholders?
- Do you think that the agreements you made will be followed by the other stakeholders?
- Do you think that stakeholders are helpful to each other?
- Do you have experience with previous cooperation with these actors?
- Do you think that the cultural background influence the cooperation?

National and international involvement

- Do you also have to work together with people from provincial and national level?
- To what extent do they influence the HIV/AIDS response on district level?
- Do you use your autonomy to establish your own policies?
- Do you experience inputs from international organizations such as WHO and UNAIDS?

General question about the LKB

- How do you assess the cooperation among the stakeholders?
- What can be improved in this cooperation among the stakeholders?
- What are, according to you, essential elements of working together?

Final questions

- Is there something that you would like to add to this conversation?
- Do you have any questions or suggestions?

After the interview

- Thank the respondent for his/her time
- Repeat the appointments that have been made

APPENDIX III: Standard Interview Protocol (Experts, PAC and NGO province)

Interviewer	
Respondent	
District	
Position	
Date of interview	
Location of interview	

Before the interview

- Thank the person for his/her time
- A short introduction of myself
- Ask the person to introduce himself/herself
- A short introduction to the research
    - Describe the aim of this research
    - Explain why the respondent is relevant to the research
    - Explain the concept and definition of governance
- Ask permission to record the interview
- Ask about the anonymity
- Let him/her sign the informed consent

Questions about the HIV epidemic in general

- Can you give a description of the HIV epidemic in the province West Java?
- Do you think that the epidemic in West Java differ from other provinces in Indonesia?
- To what extent do you think that HIV get enough attention in West Java?
- What is your opinion about the response until now?

Questions about the LKB

- In which way are you involved in the LKB program?
- Can you maybe give a short introduction to the LKB program?
- What is your opinion about the LKB program?
- Have seen changes after the implementation of the LKB program?
- How is the process of implementation going until now?

Differences among districts

- Do you see differences among the districts regards the LKB implementation?
    - Do you think that some districts performs better than others?
    - Why do you think that they differ? (Organizational, cultural, priority, etc.)
- Since this research is focused on Bandung, Bogor and Cirebon, how do you describe the response there?
    - Bandung
    - Bogor
    - Cirebon

Influence and autonomy

- To what extent does the province have influence on the local programs in the districts?
- To what extent do districts have possibilities to establish their own policies?
- Do you see the HIV/AIDS programs as a top-down or a bottom-up process?
- Do you think about autonomy for districts to implement their own programs?

Involved parties in the districts

- Who are involved in the HIV response on local level?
  - Government institutions: international, national, province and district?
  - Private sector?
  - Civil society?
- Are there more policy sectors involved in the districts?
- In which way are national and international governments involved on district level?

Meetings

- How is you relationship with the districts?
- Do you have meetings with the districts?
  - With who do you meet?
  - How often do you meet?
  - How do you describe these meetings?
  - What is the main purpose of the meetings?
  - Are always the same stakeholders represented?
- How do you describe the relation among the stakeholders in the districts?
- Do you think that they are capable to implement this program?

Questions about the meetings between the stakeholders in the districts

Boundary rules

- Who is welcome to join the meetings?
- Why is there chosen to involve these stakeholders?

Position rules

- How many people are involved in the LKB Program?
- What is your position in the LKB program?

Choice rules

- Which action have been undertaken after the introduction of the LKB program?
- How was the discussion among the stakeholders?
- Are there some stakeholders with more power than other stakeholders?
- Are there stakeholders who can influence the agenda setting process?

Aggregation rules

- How do they make decisions during meetings?
- Do they have regulations who has to make the decisions?
- Are there people who control the process of the LKB?
- Are there people from outside that can control the whole situation? (National or Provincial?)

Information rules

- Do you receive information about the progress of the program from the districts?
- How is the information distributing going between the involved stakeholders?
- Do all the stakeholders use the same information?
- Where is the information about in general?

Payoff rules

- Are there any sanctions that can be imposed for stakeholders in the districts if they do not perform well?
- Are there any positive rewards offered to participants whom function well?
- Do you think that these sanctions and rewards influence the participation of the stakeholders?

Scope rules

- Do you think that all the stakeholders recognize the HIV/AIDS problem?
- Do you think that everyone put the same amount of effort in solving the problem?
- Do you think that there are any conflicts among the stakeholders in the districts?

Final questions

- Is there something that you would like to add to this conversation?
- Do you have any questions or suggestions?

After the interview

- Thank the respondent for his/her time
- Repeat the appointments that we made

APPENDIX IV: List of respondents

No.	Area	Positon	Interviewers	Date of interview	Location
1	Province West Java	Assistant Program Manager NGO Province Level & LKB Trainer to NGOs	Ilse Damink and Febrina Maharani	19th of November 2015	PKBI Provincial NGO office, Bandung
2	Province West Java	Program Manager DAC Provincial Level	Ilse Damink and Febrina Maharani	25th of November 2015	DAC Provincial office, Bandung
3	Indonesia	PRISMA Project (Rozar Prawiranegara)	Ilse Damink	3rd of December 2015	Universitas Padjadjaran, Faculty of Medicine, Bandung
4	Indonesia	Research assistant PRISMA Project (Febrina Maharani)	Ilse Damink	3rd of December 2015	Universitas Padjadjaran, Faculty of Medicine, Bandung
5	Bandung city	Head of DHO department Communicable Disease Control and Environmental	Ilse Damink and Febrina Maharani	15th of December 2015	DHO office, Bandung
6	Bandung city	Program Manager NGO Kontak	Ilse Damink, Febrina Maharani and Wandira Larasati	16th of December 2015	Restaurant Centropunto, Bandung
7	Bandung city	Program Manager DAC Bandung	Ilse Damink and Febrina Maharani	21st of December 2015	DAC Office, Bandung
8	Bali	Scientific Expert & Manager NGO (Prof. Dr. Wirawana)	Ilse Damink	2nd of January 2016	NGO Office, Denpansar
9	Bali	Scientific Expert	Ilse Damink	2nd of January 2016	NGO Office, Denpansar
10	Cirebon district	Head of DHO Department	Ilse Damink and Febrina Maharani	13th of January 2016	Kantor Bupati, Cirebon
11	Cirebon district	Program manager DAC Cirebon	Ilse Damink and Febrina Maharani	13th of January 2016	Kantor Bupati, Cirebon
12	Cirebon district	Program manager NGO PKBI	Ilse Damink and Febrina Maharani	13th of January 2016	Kantor Bupati, Cirebon
13	Cirebon district	Head of Kesra	Ilse Damink and Febrina Maharani	14th of January 2016	Kantor Bupati, Cirebon
14	Bogor city	Secretary DAC Bogor	Ilse Damink and Febrina Maharani	18th of January 2016	DAC Office, Bogor
15	Bogor city	Program Manager DAC Bogor	Ilse Damink and Febrina Maharani	18th of January 2016	DAC Office, Bogor
16	Bogor city	Program Manager DHO	Ilse Damink and Febrina Maharani	18th of January 2016	DHO Office, Bogor
17	Bogor city	NGO	Ilse Damink and Febrina Maharani	18th of January 2016	DAC Office, Bogor
18	Bogor city	NGO	Ilse Damink and Febrina Maharani	18th of January 2016	DAC Office, Bogor
19	Bogor city	NGO	Ilse Damink and Febrina Maharani	18th of January 2016	DAC Office, Bogor
20	Bogor city	Head of DHO Department	Ilse Damink and Febrina Maharani	19th of January 2016	DHO Office, Bogor

APPENDIX V: List of documents added in the content analysis

International level

- UNAIDS. (2010). *2011-2015 Strategy: Getting to zero.* Geneva: UNAIDS. Retrieved on August 13 2015, from http://www.unaids.org/sites/default/files/sub_landing/files/JC2034_UNAIDS_Strategy_en.pdf
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National level

- Indonesian National AIDS Commission. (2009). *Strategy of the National Action Plan for HIV/AIDS 2010-2014*. Jakarta: National AIDS Commission.
- Indonesian National AIDS Commission. (2014). *National HIV and AIDS Strategy and Action Plan 2015-2019.* Jakarta: National AIDS Commision.

Provincial level

- AIDS Commission West Java Province. (2009). *Strategy for HIV and AIDS Program in West Java Province 2009-2013.* Bandung: Provincial AIDS Commission.

Local level

- AIDS Commission Cirebon District. (2012). *Strategic planning HIV/AIDS Control 2013-2017*. Sumber: AIDS Commission Cirebon district.
- AIDS Commission Bandung City. (2015). *Draft RENSTRA KPA Bandung 2014-2018.* Bandung: AIDS Commission Bandung City.
- AIDS Commission Bogor City. (2014). *Strategic planning HIV/AIDS Control 2014-2018.* Bogor: AIDS Commission Bogor city.

APPENDIX VI: List of observations

No.	Area	Meeting	Observators and translators	Date of observation	Location
1	Bandung	Meeting organized by DAC for several policy sectors	Ilse Damink, Febrina Maharani and Rozar Prawiranegara	22nd of October 2015	Hotel Gardan, Bandung
2	Bandung	Quarterly meeting among all local stakeholders (DAC, DHO, NGOs and policy sectors)	Ilse Damink and Febrina Maharani	16th of December, 2015	Restaurant Centropunto, Bandung
3	Bandung	Meeting among NGOs	Ilse Damink and Rozar Prawiranegara	19th of December, 2015	Office NGO, Bandung
4	Bandung	Meeting organized by PAC for all DACs in West Java	Ilse Damink, Febrina Maharani and Rozar Prawiranegara	22nd of December, 2015	Hotel, Bandung
5	Bandung	Meeting organized by PAC for all DACs in West Java	Ilse Damink and Febrina Maharani	23rd of December, 2015	Hotel, Bandung
6	Bali	Meeting between DAC and NGO	Ilse Damink and Anette Laras	2nd of January, 2016	Office DAC, Denpansar
7	Cirebon	Meeting between DAC and DHO	Ilse Damink and Febrina Maharani	14th of January, 2016	Office DAC and Office DHO, Cirebon
8	Bogor	Meeting between DAC and NGOs	Ilse Damink and Febrina Maharani	18th of January, 2016	Office DAC, Bogor

APPENDIX VII: Case Protocol

This case study protocol shows all the choices that are made during this research (Yin, 1994, pp.63-76).

Case Protocol Ilse Damink

Part of research	Decision moments	Choices are made
Procedures	Case selection	Multiple case study: three cases
		Most similar systems design
		Dependent variable: number of primarily health services with an HIV/AIDS department and number of people that received their testing results.
		Independent variable: unified vision and trust among stakeholders
	Researched period	From October 2015 until February 2016
	Number of measurements	One moment
Methods	Interviews	Semi-structured interviews
		Based on an interview guide
		Respondents selected through snowball recruitment
	Content analysis	Four types of documents
	Observations	Open observation
		Only notes taken
Analysis	Operationalization of theories	Done based on: theoretical definitions, dimensions, observations and indicators
	Transcriptions of interviews	Integral transcribed in Bahasa
		Fully translated to English
	Coding	Deductive codes
		Inductive codes

APPENDIX VIII: Scholarly article about the HIV/AIDS response on Bali and West Java.

Damink, I.B. (2016). *Provincial HIV/AIDS responses in Indonesia: an institutional analysis of their governance. What to learn from the different HIV/AIDS responses of Bali and West Java?* Nijmegen: Radboud Honours Academy.

Provincial HIV/AIDS responses in Indonesia: an institutional analysis of their governance

What to learn from the different HIV/AIDS responses of Bali and West Java?

For many years HIV/AIDS has been one of the most challenging global health problems. Although the epidemic is declining on global level, this is not the case for Indonesia. However, it can be clearly seen that the provincial AIDS Commission on Bali has established a more effective response than the AIDS Commission on West Java. This article attempts to expound the differences in HIV/AIDS responses in both provinces. A better economic situation, a larger amount of resources and a more open-minded cultural setting are advantages in the Balinese context that contribute to the response. Furthermore, province Bali involves relevant stakeholders more extensively and gives more direction to lower-level districts. Finally, priority-setting in interventions is a key to success since there is a clear resource gap in whole Indonesia.

1. Introduction

In 1981, the first evidence of a new disease was reported: Acquired immunodeficiency syndrome (AIDS), caused by the human immunodeficiency virus (HIV). Since the first reported case of AIDS, an epidemic has spread to all countries in the world and it has become one of the most challenging global health problems (United Nations, 2015). At the moment, there are approximately 36.9 million people infected with HIV around the world, but this number is declining globally as result of intervention programs (UNAIDS, 2013, p.4). However, not all countries have shown an effective answer to the epidemic. Indonesia is one of the few countries that is not on track for controlling its HIV epidemic. In fact, Indonesia is definitely a cause for concern since new HIV infections increased with 48% between 2005 and 2013 (UNAIDS, 2014, pp.63-64). A trend analysis of the HIV/AIDS appearance in Indonesia shows a worrisome picture. New infections among the population will increase tremendously unless the government deploys some effective policy interventions (Indonesian National AIDS Commission, 2009, p.15).

Due to the decentralized character of Indonesia, HIV/AIDS programs are established on national, provincial as well as local level. This results in significant differences among provinces in Indonesia (Heywood, 2013, p.5). The province West Java is known as a conservative and Islamic region which has clearly problems with establishing effective and accepted programs. The more open-minded and Hindustan province Bali is much further in organizing beneficial programs (WJ3;B1;B3). For that reason, it is useful to have a closer look at these two provinces in order to learn from each other. A comparison between the results will help to discover the best practices to be implemented on provincial level in the future. Therefore, the main research question of this article is as follows: *What explains the different HIV/AIDS responses of Bali and West Java?*

In order to answer the question, this article starts in section 2 and 3 with an introduction to the HIV/AIDS problem in general, in Indonesia in particular and an overview of the policies towards this epidemic. Thereafter, I will present the conceptual theoretical framework in section 4 and that helps to analyze the governance variance between the two provinces. The chosen research design and the used methods will be explained in section 5. Section 6 and section 7 contain the empirical part of this article in which the governance structures in Bali and West Java will be researched. The situational context of the provinces and the way they are organize themselves are subject of the comparison between the two regions. This comparison helps to discover the best practices. I roundup this paper in section 8 with conclusions and in section 9 with recommendations that can be used by Indonesian provinces to improve their response.

2. HIV/AIDS: an unstoppable problem

It is already more than thirty years ago that an American scientist discovered the HIV virus that can result in AIDS. HIV affects the immune system which may make infected people more susceptible to common infections than people with a healthy immune system (Lisk, 2010, p.10). According to statistics published by UNAIDS in 2014, 39.9 million people live with HIV around the world, an estimated 36 million lives have been lost due to AIDS and only in 2014 more than 2 million people were diagnosed with HIV (UNAIDS, 2014, p.1). Besides the impact on human well-being, HIV strongly affects the economic and social situation of individual people and countries. Due to the high impact of this disease, HIV/AIDS is named as an exceptional global health problem which is still not under control even after three decades. Although there is a life-saving antiretroviral therapy (ART), a vaccine has still not been developed to stop new infections. It is, therefore, that individuals also should take responsibility not to put themselves at risk of infection (Lisk, 2010, pp.2-4). Many international organizations, such as the WHO, UNAIDS and Global Fund, also take responsibility in helping countries with the development of action plans and providing ART and other necessary resources (WHO, 2015, p.13-30). Partly because of this, the number of newly infected people in the world is declining and it is expected that this decline will continue in the future. Hence, the proposition done in

the Sustainable Development Goals of the UN to stop the whole epidemic and to ensure lives and wellbeing for all infected people in 2030 might be possible to reach (UN, 2015).

However, the question is whenever all countries reach this target. Although new HIV infections is declining at global level, it is not the case for all countries. Indonesia belongs to the countries who has an upwards trend in the amount of new HIV cases. A high increase of new infections is still going on, which makes Indonesia one of the countries with the fastest growing epidemic of Asia (Evidence to Action, 2011, p.2). According to reports published by UNAIDS, within a time period of ten years HIV infections had more than doubled and the expectation is that this increase will continue significantly. The estimated HIV prevalence is especially high among female sex workers (7%), men having sex with men (8.5%), and people who inject drugs (36.4%) (Evidence to Action, 2015).

3. Governance in Indonesia's HIV/AIDS response

Due to the recognition of HIV as a normal disease, the Indonesian response has started up slowly. However, after a rapid increase of new infections and after the consensus emerged that HIV/AIDS has the potential to overwhelm the world, it was unavoidable to establish a more intensive response. Nowadays, almost all global health organization, such as the World Health Organization (WHO) and UNAIDS, use governance as their main point in organizing intervention programs effectively. Governance in the health sector refers to steering and decision-making functions carried out by decision makers. These decision makers collaborate with actors from different government layers and sectors (WHO, 2015). Indonesia also uses governance in its HIV/AIDS policy by involving civil society, private sector and other international development partners and by establishing AIDS commissions on a national, provincial and district level.

In 1987, the Ministry of Health introduced an AIDS Committee (DAC), which is mainly responsible for the development of the National HIV/AIDS strategy (Heywood, 2013, pp.18-19). This broad action plan needs the involvement of a wide range of different stakeholders as it became clear that HIV is not only a health problem (Lisk, 2010, p.26). This kind of health problems needs to be addressed from a multi-sectoral perspective. Although biomedical studies are dominant in the health sector, it has become clear that other policy sectors can also be useful in an effective health care response. Therefore, it is important to increase the involvement of other forms of expertise in health policymaking (Dodgson, Lee & Drager, 2002). A clear example is the importance of the involvement of the educational sector in the HIV/AIDS response to promote prevention programs for young people at schools.

Besides the need of a multi-sectoral perspective, health problems need also to be addressed from a multi-level perspective. In 2001 the HIV/AIDS response was fully decentralized in line with the political system in Indonesia. For that reason, AIDS Commissions have also been established on

provincial and local level. These commissions received more autonomy, responsibility and adequate resources in order to deliver and establish HIV programs on a lower level (Heywood, 2013, p.22). According to many scholars, such a decentralized way of working has several advantages compared to centralized government systems. Firstly, local users are more likely to establish successful regulations than central government systems since they have local knowledge on the resource system, the participants, etc. Secondly, because of this local knowledge, local users are able to monitor the use of resources in order to prevent abuse. Thirdly, a higher level of legitimacy may exist when new policies are introduced by their own people (Andersson & Ostrom, 2008, p.74). There are also limitations to local governance. Some local governments are not capable of organizing themselves for different reasons: it is too costly, they are afraid of a conflict among users, there is lack of leadership or they keep the fear to be overturned by higher authorities. Given the complexity of the design tasks, some local governments failure in their governance (Andersson & Ostrom, 2008, p.75). This is also what clearly can be seen in the HIV/AIDS response in Indonesia. There are several provinces who perform significantly worse with respect to others (Ristya Rahmani, 2015, p.15).

The multi-sectoral and multi-level perspectives are two essential elements of global health governance. However, as mentioned before, there are significant differences in the results between provinces as a result of their used governance style. Since all provinces benefit from a better governance structure, it is useful to have a closer look at two different performing provinces in order to learn from these differences.

4. Learning from differences

Although all Indonesian provinces work hard on their HIV/AIDS response, there is still no sign of a decline of the epidemic. However, as mentioned before, there are some parts of Indonesia that perform better in governing their response than others. Bali for example, which has worked on its response from the beginning of the virus' discovery, established an effective action plan primarily focused on prevention, care, support and treatment services (Anshori, 2015). Java, on the other hand, is trying to do the same, but due to organizational barriers, their response is known as chaotic and ineffective (WJ3;WJ4). Consequently, a situation is created in which provinces can learn from each other so that everyone will benefit from an optimal response. A method that fits the idea of learning from differences is experimentalist governance (EG). *'Experimentalist governance is an institutionalized process of participatory and multilevel collective problem solving, where the problems and the means of addressing them are framed in an open-ended way and subjected to periodic revision by various forms of peer review in the light of locally generated knowledge'* (De Búrca, Keohane & Sabel, 2014, p.2). In this research, the National AIDS Strategy and Action plan is the reference document that provides the general framework regarding the response for all provinces. The implementation of this broad framework is left to lower-level provincial stakeholders, who can adapt it to their own

circumstances. This has resulted in differences between West Java and Bali, which need to be researched extensively in order to learn from it.

The Institutional Analysis and Development Framework (IAD-Framework) formulated by Ostrom is a particular framework that helps to research the governance structure in the two provinces. It provides insight in the necessary conditions for a successful HIV/AIDS response since it contains the most general set of variables for examining diversity of institutional settings among the two different provinces (Ostrom, 2005;Ostrom, 2011). First of all, this article explores the external variables that affect the structure of the HIV/AIDS organization. These external variables include three clusters: Biophysical- and material conditions, attributes of community and the rules-in-use. Every province has its own local circumstances that influence the outcomes of their HIV/AIDS response, such as the demographic-, economic-, and social cultural situation and the availability of resources. Furthermore, the way they cooperate in, for example, meetings may differ. Therefore, it is also useful to specify this kind of action situations. Action situations include meetings with a wide range of stakeholders who are actively involved in the policy-making process. In order to research these situations, there will be a closer look on who is involved, what are their positions and how they make decisions. The final step includes the evaluation, which can be seen as the learning curve of experimentalist governance. The governance structure will be researched by the IAD-Framework which helps to discover the best practices. The IAD-Framework is depicted in Figure 1. The dotted lines are considered as 'learning curves' and help to improve HIV/AIDS responses on provincial level.

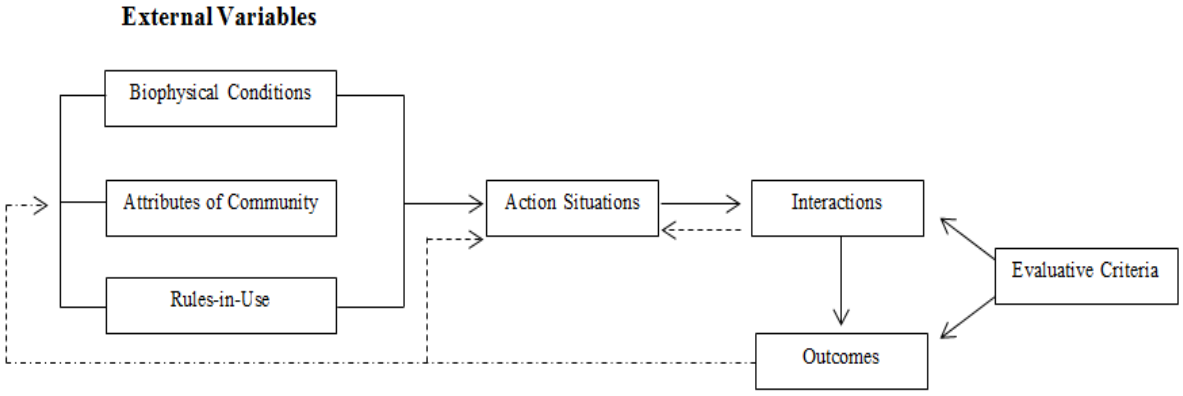

Figure 1: The Institutional Analysis and Development Framework and the experimentalist learning curve (Ostrom, 2005, p.15)

5. Methods

A multiple case study was employed to find the differences between West Java and Bali. This research design helps to understand the meanings and thoughts of the studied group to their social environment and the way they behave regarding this environment (Yin, 2003, p.13). Furthermore, it provides more information as more variables will be taken into account and it is more practical to solve the existing

problem (George & Bennet, 2005, p.19;Van Thiel, 2010, p.99). Since the social, economic and political contexts within these two provinces are likely to differ to some extent, it is useful to study them both in their own environment. Due to the choice of a most different case design, I have chosen to research West Java as a bad-functioning province and Bali as a good-functioning province. These two contrasting cases made it possible for me to compare them and to discover the best practices afterwards.

In this study, data triangulation is used in order to ensure validity. Interviews are the major source of qualitative data, but additionally observations took place and written documents were analyzed. The interviews are based on an interview guide, in which questions were formulated in advance but which still could be changed in order or content. In total 5 interviews were conducted in Bali and 4 interviews in West Java and lasted all between one and two hours. An overview of the conducted interviews among a variety of stakeholders is summarized in the table below. Besides interviews, policy documents on national and provincial level were analyzed and open observations during meetings in the province West Java took place.

Overview of conducted interviews

Bali		*West Java*	
Respondents	Code	Respondent	Code
KPA Province Program Manager	B1	KPA Province Program Manager	WJ1
KPA Province Secretary	B2	NGO Program Manager	WJ2
Professor university	B3	Head Research Team TB-HIV	WJ3
Head of NGO	B4	Staff Research Team TB-HIV	WJ4
NGO Program Manager	B5		

Table 1: An overview of the conducted interviews in Bali and West Java

6. Two different contexts

The whole organization of the HIV/AIDS response is subject to external influences created in their own environment. The local circumstances of a province can strongly differ with dissimilar outcomes as result. Therefore, it is useful to take also these variables into account since they might help to discover the key to success in the HIV/AIDS response. This chapter includes a description of the biophysical- and material conditions and the attributes of community in both Bali and West Java.

Bali

Bali is one of the most well-known provinces in Indonesia and it is a popular tourist destination for people from all around the world. Located between Java to the west and Lombok to the east, this island is relatively small with around 4.2 million residents. Bali is divided into nine different districts that all have the autonomy to establish own policies and regulations. Although it is a relatively small island, Bali is considered as one of the richest parts of Indonesia. The GDP of 38.1 million IDR per capita and a Human Development Index (HDI) of 72,48 are both significantly higher than the Indonesian average as a result of tourism and agriculture (GBG Indonesia, 2016;Badan Pusat Statistik,

2015). Despite the beneficial economic situation, Bali is one of the provinces with the highest HIV prevalence. The provincial AIDS Commission estimates that there were 12.667 cases of HIV/AIDS on Bali in September 2015, which occur mainly in three out of nine districts. In contrast to the national epidemical situation analysis, HIV transmission takes place generally through heterosexual contact between young people instead of transmitting within key populations. Partly because of the favorable economic situation, the availability of HIV/AIDS' resources are significantly high. Three of the nine districts are rich enough to provide money to other districts and even to programs organized on provincial and national level (B1). Furthermore, on Bali there are 845 health services located which almost all provide HIV/AIDS services.

Another remarkable point about Bali is the high level of cultural diversity. Apart from different religions, the Balinese population contains many different nationalities with a more open-minded view as result. According to the secretary of the KPA Province Bali, the more open-minded view helps to implement the HIV/AIDS programs easier and more effectively (B2). The challenges in convincing authorities are smaller since they do not have to take any religion or contradictory values into account. Consequently, the common understanding about HIV/AIDS in general and about the things that should be done is much higher than in other parts of Indonesia. Nevertheless, stigma and discrimination also exist in Bali. Prostitution and drugs, for instance, are still illegal which makes it necessary for authorities to prosecute them with the result that key populations do not want to enter HIV/AIDS health services (B3). Lastly, another positive attribute of the community embraces the experience stakeholders have in organizing its response. Many experts and other important people have been involved since the beginning of the virus' discovery and that is why authorities are willing to listen to them. Bali is considered as the leading province that can be used as an example for other provinces (B3).

West Java

West Java is the Indonesian province located on the western part of the island Java. This province is considered as the most densely populated Indonesian province with over 46.3 million residents. West Java is divided into 27 districts that all receive support and advice from the KPA on province level. The GDP per capita is 30.1 million IDR and the HDI is 68.80, which makes this province an average economic performer (GBG Indonesia, 2016;Badan Pusat Statistik, 2015). Together with Bali and the capital city Jakarta, West Java belongs to the provinces with the highest level of HIV prevalence. In 2014 the estimation was that 150.000 people are living with HIV and the expectation is that this group will increase dramatically in the future. The highest proportion of cases comes from transmission through infected needles and from sexual intercourse with sex workers (RENSTRA, 2009, p.5). The total amount of HIV/AIDS budget is estimated on 500 million IDR. However, most of the money is used by governors to organize world AIDS days and other events instead of direct care and prevention

for people (WJ3;WJ4). Furthermore, it is clearly visible that far from all health services in West Java provide HIV/AIDS care in health services. The percentage of health services providing HIV/AIDS care is around 40 per cent.

Having a closer look at the cultural setting in West Java, it is clear that almost all citizens follow the Islam. Several experts think that this might be one of the reasons why programs are less effective. Some governors believe that this religion should be transferred to law and that might create problems in the programs' implementation. The distribution of condoms, for example, is rejected by governors as it promotes free sex (WJ3) *'As long as we are good Muslims, we don't need condoms because we don't have free sex and that helps to decrease HIV'* (WJ2). However, all experts disapprove of this way of thinking as it results in more reported cases (WJ2;WJ3;WJ4;B3;B4, Evidence to Action, 2011, p.11). Due to the involvement of these experts in the HIV/AIDS' organization, common understanding about what should be done is still lacking. This might also be the result of the less experienced stakeholders. West Java is still highly dependent on global- and national organizations, that help them with resources and guidelines.

Comparison of the external variables

There are several contextual factors presented which explain why Bali is working well on HIV/AIDS, while West Java is still struggling. Besides a smaller geographical size and a smaller population, Bali has to govern only nine districts, whereas the province West Java includes 27 districts. Furthermore, the economic situation on Bali is significant better than in West Java. Bali is considered as one of the wealthiest parts of Indonesia, which results in a higher level of resources that can be used in their response. Also, the cultural setting on Bali is more suitable for implementing HIV/AIDS programs. Almost all people in West Java follow the Islam as religion, whereas people in Bali mainly adhere Hinduism. Partly because of the Islam, there are some challenges in convincing authorities to adopt policies that are contradictory to their religion. One example is the distributing of condoms. It is generally known that the use of condoms reduces the risk of getting HIV. However, since the Islam forbids sex before marriage, it is hard for unmarried people to get condoms with the result that they put themselves at risk (Evidence to Action, 2011, p.11). Bali, on the contrary, sees the necessity of condom use and ask governors to help them in the distribution (B2). Bali has also more experience with HIV/AIDS and has created a better common understanding among all stakeholders. All in all, the geographical, economic as well as the cultural setting makes it simpler for Bali to be more effective in responding to HIV/AIDS. However, the HIV prevalence is still quite high on Bali, which makes a further look into the internal governance structure necessary.

An overview of the two provinces

	Bali	West Java
Geographical situation		
Total population	4.225.000	43.600.000
Amount of districts	9 districts	27 districts
Economic situation		
GDP per capita	38.1 million IDR	30.1 million IDR
HDI	72.48	68.80
Characteristics of the HIV epidemic		
People living with HIV	12.667	150.000
Key population	Heterosexuals	Drugs users and sex workers
Availability of resources		
HIV/AIDS budget	Information not available	500 million IDR
Health services with HIV/AIDS care	95%	40%
Knowledge	High	Middle
Social cultural aspects		
Religion	Primarily Hindu	Islam
Multicultural	Many different nationalities	Almost only Indonesian
Common understanding	Yes	No
Stigma	Yes	Yes
Experience	Yes	No

Table 2: An overview of the external variables in Bali and West Java

7. Organizing their response

After studying the context, it is time to have a closer look at the action situation in which policy choices are actually made (McGinnis, 2011, p.173). Both Bali and West Java use their own governance style in responding to HIV/AIDS. This chapter elaborates on the most essential parts of the action situation: The stakeholders involved, the specific position they fulfill, and the resulting decisions. The decisions about the potential outcomes depend on the information available to the actors, the control each actor has over the whole situation, and the net cost and benefits associated with these decisions (Ostrom, 2005, p.32). The two essential elements of health governance, multi-sectoral and multi-level, are examined in the first two subparagraphs.

Involved stakeholders

An essential element of health governance is multi-sectoral responding. The Ministry of Health also emphasizes the importance of cooperation between different stakeholders, ranging from government officials at various levels, to private actors and civil society. Partnership and collaboration should be the hallmark of the entire response since the problem of HIV/AIDS goes beyond the health sector. Therefore, it is also highly recommended to involve other policy sectors outside the health sector. A prevention program at schools, for example, can only be implemented if the education office is willing to adopt it in the curriculum. Both Bali and West Java see the importance of involving all different stakeholders and advice districts to organize meetings with all relevant policy sectors (B1;B2;WJ1). However, whereas the provincial AIDS Commission Bali obligates districts to involve certain policy sectors, the AIDS Commission in West Java is still working on the notion of the obligation of policy broad involvement. In West Java it is up to the districts whether they involve other offices than the health office (B3;WJ1). Nevertheless, although different policy sectors are involved on Bali, not all of

them work well on this issue. Policy sectors, such as transportation and education, are still not familiar enough with this issue to give it enough attention (B5). Another remarkable point that came up during the interviews is the involvement of the mayor. The district mayor always has the position of chair in an AIDS Commission, but the level of involvement differs strongly between Bali and West Java (WJ4). There are some districts in West Java where involvement of the mayor is clearly visible, but in most places the mayor does not pay proper attention to this health issue (WJ3). In Bali, in contrast, mayors agree on being involved in the response as they acknowledge that they can play an important example role (B3). Also, due to the high number of Australian tourists in Bali throughout the year, the Australian government supports the province Bali with the so called AusAid Fund. Bali has better connections with international organization, and therefore, international organizations fulfill also positions as stakeholder in the Balinese HIV/AIDS response (B1;B3).

Positions of the provincial AIDS Commission

Because of the decentralized system in Indonesia, national, provincial and local level stakeholders work on this issue in which all have their own responsibilities. Local users are more likely to establish an effective HIV/AIDS response as they are more familiar with their own circumstances. The general agreement is that districts needs to organize their own response with some steering from the provincial level. Since my research focused primarily on provincial level, it is useful to have a closer look at how the two provinces fulfill their position as steering actor. Although the provincial KPA on Bali sees the importance of districts' empowering, the province still have a duty to provide the guidelines (B1;B2). All districts have autonomy to determine their own response, but most districts just replicate provincial plans. The provincial KPA gives the reason that Bali is small enough to be coordinated by the province. Districts do not see the necessity of making own plans as it is seen as double work (B3). The province West Java fulfills only the role as guider instead of provider. According to the KPA program manager, districts should formulate their own response based on the particular epidemic situation (WJ1). Where the province Bali uses a top-down system in which HIV/AIDS programs are directed to the districts, West Java uses a bottom-up process in which districts should come up with their own ideas and plans based on their context.

Decision-making based on priority setting

The involved stakeholders who are all assigned to certain positions come together in action situations to make decisions. These decisions are highly dependent on the information available, the control each actor has over the whole situation, and the net cost and benefits associated with the decision (Ostrom, 2005, p.32). One of the decision-methods that is included in this article is based on priority-setting. Due to the lack of resources, all Indonesian provinces face a resource gap in their budget. The total funding needed in 2013 was estimated to be 107 million USD whereas only 84 million was available. This enormous resource gap is expected to expand further as the number of new infections is

increasing, while international donors are likely to decrease their funds (Indonesian National AIDS Commission, 2014, pp.23-28). Therefore, many experts advocate priority-setting in which health interventions should be decided based on solid consideration. HIV/AIDS programs should not only be tested on effectiveness, but also whether it is worth the costs (Tromp, 2015, pp.5-7). Bali is one of the provinces that already use priority-setting in making decisions on interventions. The provincial AIDS Commission admits to the lack of budget, and therefore an extensive research is done to spend the budget as effective as possible. This research has shown that between the 70 and 80 per cent of all cases is reported in three particular districts. These three districts are more urbanized and consequently have more cases among key populations. Due to these investigations, both AIDS Commission, NGOs, and even the professor focus on these three districts as numbers has shown that the core of the problem is located here. Furthermore, this analysis gave insight in the nature of the problem, which makes it easier to make affordable decisions that fits the epidemical situation. Stakeholders in Bali have more information available and have a better view on the net costs and benefits, which makes it easier for them to decide on effective outcomes. West Java, on the contrary, decided to divide their budget among all 27 districts. Every district received the same amount of money regardless the contemporary epidemical situation. The information system in West Java is less developed with the consequence that province KPA does not have the possibility to make well considered decisions (WJ2).

8. Conclusion

Although Bali and West Java have been working on the HIV/AIDS problem for many years, it has still not resulted in control of the epidemic. However, it becomes clear that Bali works more effectively than West Java. Therefore, the main research question of this article is as follows: *What explains the different HIV/AIDS responses of Bali and West Java?* An in-depth research on their used governance styles is examined by the IAD-Framework. This particular framework has shown better governance conditions in Bali as they involve relevant stakeholders more extensively and they provide better guidelines to lower-level districts.

Apart from that, Bali has several situational context advantages that contribute to their response. First of all, Bali has several demographic advantages such as a smaller population, a smaller territory and consequently less districts to govern. Secondly, Bali possesses more resources due to a better economic situation. Thirdly, there is a better cultural setting for HIV/AIDS on Bali as a result of the religious situation, more external influence and more experience with this issue.

There are also differences found in the actual action situation. First of all, the two provinces use different ways of the multi-sectoral approach. Although both provinces admit the importance of involving a wide range of stakeholders, the provinces facilitate the cooperation between public, private and civil society organizations in different ways. The province Bali requires districts to facilitate these

partnerships, whereas West Java only advices it with the consequence that districts differ from each other. The level of involvement of mayors is also different. Since leadership of mayor plays a significant role in Indonesia, Bali attempt to involve their mayors considerably, while mayors in West Java shortages in it.

Multi-level governance has also a different meaning in Bali and West Java. The role provincial AIDS Commissions have towards the districts differ significantly. The province Bali uses the top-down system in which HIV/AIDS programs are directed to the districts. West Java uses the bottom-up process in which districts should come up with their own ideas and plans that fit their context. According to many scholars, including Elinor Ostrom, it is important to involve local communities in a decentralized system as they are more familiar with local circumstances. The situation in West Java would be considered as the best option. However, interviews within the districts and the context analysis show that most West Javanese districts are not capable enough to do this because of insufficient resources, commitment and leadership. Therefore, the question arises whenever a decentralized system fits the present situation.

Finally, both provinces use different ways of making decisions in for example their budget allocation. Due to the resource gap, it is necessary to have an extensive examination in order to get insight in priorities. Bali is already using this system by doing research on the core of the HIV/AIDS problem. This helps them to use money on issues that have more priority to be solved. West Java, in contrast, divides their budget among all districts where after the districts can decide how to use their money. Consequently, money is used for topics and events that do not necessity have priority (WJ1;B3;B4).

9. Recommendations

After the analysis of the HIV situations in Bali and West Java, it became clear that Bali works more effective as result of better contextual situations and better governance conditions. This research gives West Java the possibility to learn from Bali, and therefore, some recommendations will be given as final part of this article.

First of all, the existing cultural aspects in West Java are considered as limitations in their HIV/AIDS response. However, this part of the problem is hard to change as culture is strongly imbedded in the whole society. It would not be effective when governors attempt to neglect the citizens' culture, and therefore, I can only recommend the province West Java to be aware of their own limitations. Furthermore, as I expect that it would be difficult to be that opposing governor, I recommend the province to involve outsiders whom cannot be blamed for outside the box thinking.

Secondly, the comparison between Bali and West Java made clear that it would be easier to govern less districts instead of the 27 districts that need to be steered now. However, demographical changes in the size of the province would have too much impact on everything, and therefore, I recommended the provincial AIDS commission to appoint responsible speaking persons for a certain amount of districts. The provincial AIDS commission might get a better view on the districts and districts know better to who they can go with their questions. This results in a better understanding between the two government layers, which help to improve them both.

Thirdly, due to the lack of economic resources, it would be useful for the province West Java to implement priority-setting in for example distributing Global Fund. Currently, many different donors, political powers and other governors have influence on HIV/AIDS resource allocation, while there is a lack of guidance for an effective response. Therefore, an improvement in priority-setting is needed to respond effectively to the epidemic and to make the government accountable for their actions. Instead of the cost-effectiveness analysis, which is based on the underlying thought that intervention should be both effective and worth its costs, I recommend to use multi criteria decision analysis (MCDA). This way of analyzing contains a wide of range criteria, such as ethical and cultural considerations, which also play an important role in the decision making process. The provincial AIDS Commission in West Java should implement a systematic process for incorporating multiple criteria in decision making process in order to create transparency on the impact of HIV interventions.

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