



Australian Government
AusAID



Australia–Indonesia Partnership for Health Systems Strengthening 2011–2016

Program design document

November 2011

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Executive summary

The Australia–Indonesia Partnership for Health Systems Strengthening 2011–2016 (AIPHSS) will support the Government of Indonesia’s plan to strengthen health systems and achieve the health Millennium Development Goals (MDGs), in particular the maternal mortality MDG, which is seriously off track. The Ministry of Health of Indonesia engaged strongly in the design of the program and views it as an important part of its own plans. The program aligns with the Ministry of Health Strategic Plan 2010–2014 and has targets and indicators linked to the plan’s performance matrix. It also aligns with the Government of Indonesia’s Roadmap to Accelerate Achievement of the MDGs in Indonesia, which includes an explicit commitment to achieve the maternal mortality MDG. The program’s design process ensured a high level of Ministry of Health ownership and leadership of the program, and its intended deliverables and implementation modality.

The program’s impact (goal) is to improve the health status of poor people. The impact will be measured beyond the life of the project by improved maternal mortality rate and improved under-five mortality rate. The outcome (purpose) will be the improved use of quality primary health care and referral to the right type of care at the right time to best protect the life of mothers and children. This will contribute to achieving the health MDGs in 20 districts in five provinces. The program intends to strengthen health financing and human resources for health, and thereby contribute, in support of other Government of Indonesia plans, to improving maternal and child health outcomes. The program impact, outcome and outputs have been negotiated with strong Ministry of Health ownership and leadership. The program aims specifically to increase the use of primary health care by the poor and near-poor. Program monitoring will include collection and analysis of data by socioeconomic status to track the benefits the lowest quintiles gain from program.

The program was designed on the basis of a problem analysis that suggested that improving health outcomes of poor people requires interventions and capacity development at the service-delivery level of Puskesmas (Pusat Kesehatan Masyarakat (primary health care community health centre at the sub-district level)), the management and supervision level of districts and provinces, and the policy and stewardship level of national government.

AusAID support will be partially harmonised with the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) Health Systems Strengthening (HSS) support to strengthen primary health care services for poor people. AusAID support will improve the efficiency of health financing and increase the number, quality, distribution and effectiveness of primary health care workers. The AusAID investment will be up to \$50 million for five years, from 2011 to June 2016. The Global Fund investment will be US\$37 million for five years. The Australia–Indonesia Partnership for Health Systems Strengthening will deliver its own benefits in support of the national health plan. By linking with the Global Fund HSS program, it provides an opportunity for AusAID to engage the

Government of Indonesia in policy dialogue to maximise the benefits of Australia's investments through the Global Fund. These include both core contributions and the Debt2Health agreement in Indonesia. It also maximises government's ability to harness external resources to strengthen health systems.

The program will contribute to achieving the outcome through addressing key supply-side obstacles to improving primary health care. Access to primary health care, particularly for poor women, is limited by problems of affordability, distance to the nearest health worker or facility, and sociocultural factors. The program aims to reduce the barrier of affordability to increase demand for primary health care but will rely on other interventions and programs to address other demand-side factors (for which there are other AusAID programs). The quality of primary health care includes the quality and safety of the services delivered, and considerations of infrastructure, medical supplies and equipment. Health financing and the quality, supply and distribution of human resources for health are the focus of the program because of their centrality to access to and the quality of primary health care.

AusAID support will result in achieving five outputs (end-of-project outcomes):

Output 1: The Ministry of Health uses evidence-based data and up-to-date information to make national-level policy decisions on health financing and health human resources to improve access to and the quality of primary health care for the poor and the near-poor.

Output 2: Health offices in 20 districts in five provinces implement health financing and human health resources policies and programs more effectively and efficiently to improve access to and the quality of primary health care for the poor and the near-poor.

Output 3: Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in 20 districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor (Puskesmas achieve Poned status, that is, the management of basic emergency obstetric neonatal care).

Output 4: The Center for Health Workforce Education and Training (Pusdiklatnakes) ensures that selected government health polytechnics (Poltekkes) run accredited nursing and midwifery study programs (Program Studi Kabidanan Perawat (Prodi)) to produce qualified nurses and midwives for the selected primary health care and village health posts.

Output 5: Universities, research institutes and civil society organisations are able to deliver evidence-based data, advocate for health financing and human resources for health with the central and local policy-makers, and provide technical assistance and training to districts and Puskesmas to increase health access for the poor and the near-poor.

The AIPHSS program's national, provincial and district activities will be implemented by a Program Management Unit (PMU) in the Bureau of Planning and Budgeting in the Ministry of Health. In addition, AusAID will contract an Implementing Service Provider (ISP) to provide technical assistance, recruit a Monitoring and Evaluation Adviser, and manage a Health Policy Network and a Civil Society Challenge Fund.

The program design process emphasised strong government ownership and leadership, and a government-led implementation modality. The program was designed with a long-term vision of creating the opportunity for a second phase of funding to the program after 2016 to support further scale-up of the interventions. The partial harmonisation of AIPHSS with the Global Fund HSS program demonstrates how other interested donors could bring additional support.

1 Analysis and strategic context

1.1 Country and health sector issues

Indonesia is the largest national economy in Southeast Asia. It has recorded sustained economic growth since 1997–98. Gross domestic product (GDP) is expected to increase by 6 per cent in 2011.¹ The population is over 230 million, of whom 30.02 million people (12.49 per cent of the population) live below the national poverty line.² The World Bank estimated in 2010 that approximately 120 million people are ‘near-poor’, that is, their consumption levels are below US\$2 per day. Total expenditure on health per capita increased from US\$19.8 in 2002 to US\$55.4 in 2009.³ Government expenditure on health is relatively low as a proportion of total government expenditure—6.2 per cent in 2007—up from 4.5 per cent in 2000.⁴ However, government expenditure on health has also increased significantly, from 42 per cent of total health expenditure in 1996 to 50 per cent in 2006.

Health outcomes have not kept pace with the country’s economic growth and increased investment in health. Maternal mortality is particularly bad for a middle-income country: the rate of 228 per 100 000⁵ is very similar to that of Burma (219 per 100 000) and much worse than that of Vietnam (64 per 100 000), both characterised as low-income countries.⁶ Philippines and Indonesia have similar gross national income (GNI) per capita (purchasing power parity) (\$3900 to \$3830) but dissimilar maternal mortality (84 compared with 228 per 100 000). Infant mortality and under-five mortality rates are also higher than those of other comparable countries, and immunisation coverage is low (77 per cent) (Cambodia and Vietnam are both above 90 per cent). Non-communicable diseases are on the rise, resulting in an increasing double burden of disease. The higher disease burden combines with rising life expectancy to increase pressure on the health system.

The Government of Indonesia is committed to achieving universal coverage of health insurance and has put the legislative framework in place to do so. The Ministry of Health Strategic Plan 2010–2014 includes targets to strengthen primary health care and decrease actual maternal mortality, and the Government’s Roadmap to Accelerate Achievement of the MDGs in Indonesia has an explicit commitment to reduce maternal mortality to achieve the MDG. These policy commitments are backed up by higher levels of

¹ www.worldbank.org.

² BPS, Social Economic Data Monthly Report, July 2011.

³ Indonesia – National Health Accounts 2005–2009: Public Sector, January 2011.

⁴ WHO, World Health Statistics 2010.

⁵ BAPPENAS, ‘A Roadmap to Accelerate Achievement of the MDGs in Indonesia’, 2010.

⁶ Chongsuvivatwong, J et al., The Lancet Series Health in Southeast Asia 1: Health and health-care systems in Southeast Asia: diversity and transitions. Vol 377, January 29, 2011.

government funding for health. An estimated 85.9 million people had health insurance coverage in 2005, approximately 41 per cent of the population (this assumed full coverage of the poor through Jamkesmas—Jaminan Kesehatan Masyarakat (Basic Health Insurance for the Poor Program)—which was not the case).⁷ Almost 60 per cent of the population, therefore, does not have health insurance and risks financial distress because of the high cost of health care. The Government has increased funding for a number of priority health issues, including the Bantuan Operasional Kesehatan (Block Grant Program (BOK)—operating costs for primary health care), Jamkesmas and Jampersal (Jaminan Persalinan—targeted funding for free maternity care). But evidence suggests that these funds may not be reaching front-line primary care services for the poor.

The last 10 to 12 years have seen a shift in the responsibility for financing, planning and delivering health care from the national level to the district level, as part of broader national decentralisation programs. The rapid decentralisation, however, has not been accompanied by sufficient development in the capacity of district level health officials to fulfil their new responsibilities. Their weak capacity causes major bottlenecks in the use of national and district finances to deliver health care. The cumbersome planning process, which requires district plans to be developed that flow up to provincial and then national plans for approval, can lead to delays of up to six months in disbursement of the annual health budget. The problem is further compounded by insufficient communication between the Ministry of Health and the Ministry of Finance, and the Ministry of Finance's lack of willingness to allocate sufficient funds to comply with the Health Law No. 36 (2009) (see Annex 1).

1.2 Poor people and health care in Indonesia

While it is the poor who make greater use of underfunded primary health care in Indonesia, they are not benefiting from publicly funded health care in proportion to their numbers. The majority of government health expenditure is on secondary care, and poor people have very little access to public hospitals. One consequence of this is that only 13 per cent of the poorest quintile benefit from public funding to hospitals.⁸ In 2006 the poorest two quintiles constituted over 40 per cent of the use of primary health care but only 20 per cent of the use of hospitals. There are vast geographic inequities in district and national government health spending by province. Typically, poorer regions, including the two initial program provinces, Nusa Tenggara Timur (East Nusa Tenggara) (NTT) and East Java, have much lower levels of health expenditure than other provinces.⁹

Poor people are greater users of primary health care, but often have to rely on low-quality primary health care. Primary health care financing is relatively low, a problem that is compounded by the fragmented nature of health funding streams from the national level to the districts and to Puskesmas. The funding problem reduces the efficiency of primary health care budget allocations, many of which are underspent at the end of the year. In addition, health workers are not well distributed throughout the country; there are critical vacancies in many Puskesmas, particularly in remote and poor areas. The skills mix can be inappropriate, and the level of staff training and experience insufficient, for the health

⁷ World Bank, *Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending*, 2008.

⁸ *Ibid.*

⁹ *Ibid.*

issues and complications that health workers face. Restrictive national regulations on appointing health workers as civil servants limit the possibilities for districts to innovate and find local solutions to their shortage of health workers.

Many poor people who are entitled to free care under the Jamkesmas scheme are not currently participating.¹⁰ Estimates of the proportion of total health expenditure that is spent by people out of pocket vary from 30 per cent (according to WHO data) to 48 per cent (World Bank). For the large number of poor or near-poor, the high cost of health care poses substantial risks. In 2006, 1.2 per cent of households suffered catastrophic health expenditure (a reduction from 1.5 per cent in 2005).¹¹ Impoverishment as a result of health care costs also decreased slightly, from 1.2 per cent to 0.9 per cent of households, between 2005 and 2006. Despite the slight improvements, these figures represent a significant number of Indonesia's 230 million people.

Cost is not the only factor that affects poor people's access to quality health care. For people living in many remote areas and smaller islands of Indonesia, geographic factors affect proximity and access to health care. Many of the interventions required to improve child and maternal health require effective primary health care to deliver immunisation, antenatal care leading to safe births, and integrated child health services. However, the use of primary health care by the poor is low because of perceptions of high cost and low quality. Many Puskesmas do not have the staff they need, including doctors, nurses and midwives. Their health workers often lack the necessary skills, or do not see sufficient numbers of cases to maintain a high level of skill and experience in managing complications. The lack of application of nursing and midwifery standards in some districts can be a contributing factor to the poor skills base of the health workforce. Crucially for maternal health, referral pathways from primary care are unclear or inefficient, which results in unnecessary deaths when obstetric complications occur.

Finally, national health policies are sometimes made without due process to gather and analyse the appropriate evidence to inform policy options and choices. Insufficient data are generated and analysed on whether and why poor people are benefiting from public health expenditure.

There are, of course, multiple other determinants of health in Indonesia, including access to safe water, sanitation, and education.

In summary, the evidence suggests that poor people are disproportionately not benefiting from public expenditure on health care. Poor people use primary health care more than secondary care, although use is below expectations. Primary health care is underfunded and understaffed, and funding streams are inefficient. The situation is worse in poorer, remote and rural districts. Many of the key interventions that would help Indonesia to achieve the maternal health MDG could be delivered by Puskesmas with efficient referral pathways for emergency obstetric care.

1.3 Lessons learned

The AIPHSS program can benefit from the important lessons from AusAID support for the Australia–Indonesia Partnership for Maternal and Neonatal Health (AIPMNH), which

¹⁰ World Bank: Indonesia Health Sector Review: Does Jamkesmas Protect the Population from Health Expenditure Shocks?

¹¹ World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

addresses similar health systems constraints. A key lesson from this partnership is that weak capacity at district and Puskesmas level can be addressed using donor funding and technical assistance to improve health care delivery. This can be done through improving planning and budgeting, and workforce quality and availability. A second lesson is that it is difficult to develop full national and local ownership and leadership of a donor-funded program when responsibility and accountability for funding and decision making lie with an externally contracted implementer.

There are many potential lessons from international health systems strengthening programs. First, primary health care is an appropriate focus for a health systems program that aims to benefit the health of the poor. Quality, accessible primary health care is cost effective and vital to any health system in a country that aspires, as Indonesia does, to have universal coverage.¹² Second, in a large country with a highly decentralised fiscal and political system, health systems strengthening requires interventions at both the national (or policy) and district (or delivery) levels. Finally, in a middle-income country, the challenge for a donor is not what its project can do but how its comparatively small level of funding can best leverage increased efficiency and effectiveness from the considerably larger scale national health budget. This can only be achieved by working within national programs. A program modality that links national policy work to district implementation is essential.

1.4 Consistency with existing AusAID and other donor and multilateral programs

Pillar 2 in the Australia–Indonesia Partnership Country Strategy 2008–13 is ‘Investing in People’, which states that Australia will work with Indonesia to deliver better access to health and better health systems. The AIPHSS program is consistent with that objective and will underpin the existing AusAID support to Indonesia for maternal and neonatal health, HIV/AIDS and emerging infectious diseases. Health systems, and by extension this program, contribute to achieving the goals of these other projects because strong health systems are needed to deliver emergency obstetric care, to provide AIDS treatment, and to respond to emerging infectious diseases.

The program will also align geographically with the Australia–Indonesia Partnership for Decentralisation (AIPD) and, with its specific health focus, will fit well with the partnership’s broader supply- and demand-side activities to achieve improved resource allocation at the subnational level.

This program is designed to be partially harmonised with the Global Fund HSS program, which will provide US\$37 million between 2012 and 2016 to focus on strengthening health information systems, and procurement and supply chain management. The Global Fund is the largest other donor that supports health systems. The Global Fund’s focus on health information systems and procurement and supply chain management complements and reinforces AusAID’s focus on health financing and human resources for health.

There are few other donors funding health systems strengthening in Indonesia. GAVI Alliance approved a US\$24 million grant for HSS in Indonesia in 2008, for five years to 2013. The grant has suffered from slow implementation—to date only US\$3 million has

¹² World Health Organization: World Health Report 2006.

been disbursed. However, it is to be reprogrammed and will coordinate with the Global Fund and AusAID HSS investments. The Government of Indonesia is unlikely to take further loans from the World Bank or the Asian Development Bank for health systems because of its relatively strong health infrastructure, and the higher loan repayments it would have to make as a middle-income country. The World Bank produces high-quality health financing and systems analysis that the program could link with in the future. USAID, the other large bilateral donor to health in Indonesia, is not investing in health systems strengthening, and the German Association for International Cooperation will exit the health sector in Indonesia at the end of 2011. The World Health Organization is not strongly active in health systems strengthening in Indonesia.

1.5 Rationale for AusAID involvement

AusAID is increasing its investment in the health of poor people globally. Australia's largest development partnership is with Indonesia, where there are over 100 million poor or near-poor people. Many of them are not accessing quality primary health care, or are vulnerable to the shock of catastrophic health care costs. Indonesia is a middle-income country that has a policy of universal coverage, is increasing government expenditure on health, and has the fiscal space to continue to increase that spending. The rationale for AusAID to work with government in Indonesia on health systems is to help ensure that increased government funding for health benefits the poorest. The analysis of primary health care delivery (outlined in Annex 1) suggests that key issues to be addressed include increasing the efficiency of existing health resources for primary health care and increasing the quality, number and distribution of primary health care workers, in particular nurses and midwives. In addition, analysis of the political economy of the health sector suggests that a critical obstacle to increasing the effectiveness and efficiency of health spending is the limited capacity at the district level, which has the prime responsibility for funding, planning and delivering health care in highly decentralised Indonesia. Because of those factors, AusAID has an important role to bring funding, technical assistance and international best practice and innovation to help government ensure that poor people benefit from public funding for health.

Another rationale for AusAID to invest in health systems in Indonesia is to maximise the benefits of its existing programs. First, there is a global recognition that vertical health programs (such as maternal and child health, HIV/AIDS, and immunisation) are unsustainable and do not deliver their full potential if they are not complemented by system strengthening. For this reason, this program provides a vital underpinning to assist Indonesia to achieve its health MDG targets. The program complements AusAID's existing portfolio of development support in Indonesia. Second, under AusAID's Debt2Health Swap arrangement with the Global Fund and Government of Indonesia, Australia forgoes the repayment of debt by Indonesia in return for investment by the Government of Indonesia in Global Fund-approved tuberculosis programs in Indonesia. AusAID support for health systems in Indonesia, harmonised with the Global Fund, will underpin higher performance of these other programs. Finally, AusAID support will focus on publicly, not privately, funded health care and seek to influence the efficiency of rising public health care expenditure.

2 Program description

The AIPHSS program was designed through extensive consultation and collaboration between the Ministry of Health and AusAID.¹³ The impact, outcome, outputs, indicators and modalities have been negotiated and agreed in joint workshops with strong Ministry of Health leadership. The program will support the Government of Indonesia's plan to strengthen health systems and achieve the health Millennium Development Goals. The program aligns with the Ministry of Health Strategic Plan 2010–2014 and has targets and indicators linked to the plan's performance matrix. It also aligns with the Government's Roadmap to Accelerate Achievement of the MDGs in Indonesia, which includes an explicit commitment to achieve the maternal mortality MDG. The design process has resulted in a high level of Ministry of Health ownership and leadership of the program, and its intended deliverables and implementation modality. The program is designed on the basis of a problem analysis that suggested that improving health outcomes of poor people requires activities and capacity development at the implementation level of Puskesmas, the management and supervision level of districts and provinces, and the policy and stewardship level of national government. Through strengthened health financing, human resources for health and policy decisions at national, provincial and district levels, the program contributes, in support of other Government of Indonesia plans, to improving maternal and child health outcomes. Annex 9 sets out the problem analysis and program theory of change. AusAID is engaged in ongoing discussions with the Ministry of Finance, Badan Perencanaan Pembangunan Nasional (National Development Planning Agency) and the provincial governments to broaden government ownership. This collaboration is critical for successful program implementation.

2.1 Impact and outcome

The impact (goal) of the AIPHSS program is improved health status of poor people. Progress towards this goal can be measured beyond the life of this program with indicators on maternal mortality and under-five mortality. The program outcome's (purpose) will be the improved use of quality primary health care and appropriate referral to the right type of care at the right time to best protect the life of mothers and children. This will contribute to achieving the health MDGs in 20 districts in five provinces. The focus of the program will be to increase the use of primary health care by the poor and near-poor. This will be tracked by collecting and analysing data that will be disaggregated by socioeconomic status, specifically, by income quintiles. The program will contribute to achieving the outcome by addressing key supply-side obstacles to improving primary health care and by improving the poverty focus and effectiveness of

¹³ A series of roundtable consultations on health financing, health human resources and on mainstreaming gender in the health system were also conducted in early 2010.

national and local policy, planning and budgeting for service delivery. The key constraints that this program will address are health financing and human resources for health (see Annexes 1 and 9). A key health financing constraint is the highly fragmented nature of government health financing and the slow disbursement process, while the main human resources constraint is the 'mutasi' (the continual turnover of staff at all levels of the health system) of staff in health management and health service delivery positions. Both constraints have technical and political aspects. The program was designed as a tool that the Ministry of Health could use to address those constraints, and other issues, at national, provincial and district levels. It will also address the major demand-side barrier of the high cost to poor people of primary health care. The program will improve access to better primary health care services where poor people are the major users. It will strengthen national, provincial and district systems for monitoring health service delivery, health-seeking behaviour, and health care use by poor people.

Access to primary health care, particularly for poor women, is limited by problems of affordability, distance to the nearest health worker or facility, and sociocultural factors. Quality of primary health care includes the quality and safety of the services delivered and considerations of infrastructure, medical supplies and equipment. The quality, supply and distribution of health financing and human resources for health are the focus of the program because of their centrality to improving access to and the quality of primary health care.

Australia's contribution to efforts to achieve these goals is to support activities to contribute to five program outputs:

Output 1: The Ministry of Health uses evidence-based data and up-to-date information to make national-level policy decisions on health financing and health human resources to improve access to and the quality of primary health care for the poor and the near-poor.

Output 2: Health offices in 20 districts in five provinces implement health financing and human health resources policies and programs more effectively and efficiently to improve access to and the quality of primary health care for the poor and the near-poor.

Output 3: Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in 20 districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor (Puskesmas achieve Poned status, that is, the management of basic emergency obstetric neonatal care).

Output 4: The Center for Health Workforce Education and Training (Pusdiklatnakes) ensures that selected government health polytechnics (Poltekkes) run accredited nursing and midwifery study programs (Program Studi Kabinanan Perawat (Prodi)) to produce qualified nurses and midwives for the selected primary health care and village health posts.

Output 5: Universities, research institutes and civil society organisations are able to deliver evidence-based data, advocate for health financing and human resources for health with the central and local policy-makers, and provide technical assistance and training to districts and Puskesmas to increase health access for the poor and the near-poor.

Outputs 2 and 3 are the most critical for achieving the program outcome. Output 4 is an investment in future staffing for primary health care. Outputs 1 and 5 ensure a linkage between national policy development and district implementation, and provide an in-built

mechanism for lessons from this program to be rolled out to other provinces and districts in the future. Output 5 engages with civil society and academia outside of the health bureaucracy to:

- > advocate for increased government expenditure on health
- > advocate for improved district- and facility-level accountability for health expenditure
- > conduct research on poor people's health care, for evidence-based policy and transparency of implementation.

The program focuses on supply-side issues, and does not have a strong focus on addressing individual and social barriers to health-seeking behaviour other than reducing the major barrier of affordability. International evidence suggests that major increases in use can be achieved by addressing supply-side constraints and removing the financial barriers to health care. Other programs address demand-side issues, including the Government's National Program for Community Empowerment—Healthy and Smart Generations (PNPM Generasi), which provides cash transfers to communities for health and education; and AIPD. There is scope for future phases of programming to include interventions to increase demand for health care, but it was viewed as appropriate, and more ethical, to improve quality and affordability of primary health care first.

2.2 Indicative interventions to achieve program outputs

An indicative set of interventions and activities essential for achieving program outputs has been developed and agreed with the Ministry of Health. These are outlined in Annex 6. Examples include:

- > **Output 1:**
 - technical assistance to the Ministry of Health to improve human resources information systems
 - funding to support research on poverty, equity and health
 - support for data analysis, policy studies and innovation to improve health financing mechanisms
- > **Outputs 2 and 3:**
 - technical assistance to provincial health offices to increase leadership and supervision of district health offices
 - technical assistance to district health offices to build capacity to improve planning and disbursement of health financing and distribution of human resources and to carry out their supervisory role to ensure that service standards are met
 - training and capacity building for Puskesmas to better use existing health financing arrangements, working with the district health offices and national Ministry of Health to identify bottlenecks that are leading to increased out-of-pocket expenditure and reduced access
 - facilitation of policy dialogue on potential policy solutions
 - assistance with trialling new mechanisms to overcome barriers to the efficient flow of funds to service delivery and beneficiaries

- funding and training to increase staff skills to deliver primary health care that meets national standards. This will include funding for research, technical assistance and training to build institutional and individual capacity
- > **Output 4:**
 - funding and technical assistance to the Ministry of Health to support Poltekkes to improve training standards for midwifery and nursing to meet new accreditation standards
 - support to Poltekkes to meet the new standards
- > **Output 5:**
 - funding and technical assistance to support a Health Policy Network of universities and research institutes to conduct research and generate data on poverty and equity in health care, including capacity to make research more accessible to policy-makers
 - funding for a Civil Society Challenge Fund to enable civil society to advocate for more funding for primary health care, and for poor people to use primary health care.

2.3 Selection of provinces and districts

The criteria for selection of provinces and districts are as follows:

- > were classified as poor
- > had low performance on key health indicators
- > had existing AusAID support (especially NTT—AIPMNH and AIPD)
- > had district leadership that demonstrated political will to improve health systems (measured by money it allocated to health and its history of strengthening health systems)
- > were aligned with districts chosen for implementation of the Global Fund HSS program and other donor support
- > provided examples for scaling up.

Two of the five targeted provinces have been agreed: East Java and NTT, and district selection within those provinces is underway. Selection of subsequent provinces and districts will be endorsed by the Program Steering Committee.

A new presidential decree (PP10/2011) on the management of loans and grants states that local government should provide assistance for grants in the form of staffing and that a letter of support must be supplied by the district head and head of the local parliament.

Interventions at the subnational level afford the opportunity for the program to work collaboratively with the Global Fund HSS investment and also GAVI Alliance HSS, USAID maternal and neonatal health programs and UNICEF child health projects.

2.4 Forms of aid proposed

The modalities for delivering the HSS program were considered against criteria agreed with the Ministry of Health. The best design for the program was considered to be one which:

- > is most likely to support the achievement of project outcomes
- > is most likely to support national ownership and leadership
- > includes robust financial risk management to protect AusAID funds from misuse or leakage
- > maximises policy dialogue between AusAID and the Ministry of Health
- > minimises transaction costs for AusAID and the Ministry of Health
- > is flexible to allow scale-up with additional resources in the future
- > may be extended beyond the first five years
- > can accommodate other potentially interested donors
- > is based on international best practice
- > can start quickly (in early 2012).

The program design that best fits the criteria is a government-led program with grant funding to be managed by a PMU in the Ministry of Health to implement national, provincial and district activities. The PMU will be supplemented by an ISP to provide technical assistance and manage the Health Policy Network and the Civil Society Challenge Fund.

Other forms of aid considered included partnering with a development bank or UN agency, providing sector budget support or engaging a private sector managing contractor. The strongest alternative option would have been a World Bank Trust Fund. That alternative was discounted because of the low interest of the Ministry of Health in taking out additional World Bank loans for the health sector, and the risk of reducing national ownership and of limiting AusAID policy dialogue with the Ministry of Health. It would also have required a much longer design process. However, the program should keep open the option of linking with the World Bank on future analytical work as long as this work is conducted in a way that ensures government ownership of the results and findings. There are no UN agencies with a track record or expertise in strengthening health systems in Indonesia to consider for this type of program. The option of engaging a private sector managing contractor was also considered but it was determined that such an arrangement would be unlikely to achieve the high level of partner government ownership and leadership required. Sector budget support was discounted for two main reasons: first, the health sector in Indonesia does not score well against AusAID's financial risk management criteria, and second, there is the risk that the level of AusAID funding, by being relatively low compared to government funding, would not leverage sufficient additional results and could suffer the same inefficiencies that affect disbursement and use of the government budget.

The design proposes partial harmonisation with the Global Fund HSS program (the details are outlined in Section 3: Implementation arrangements). The principal benefits of this approach are:

- > use of the existing and proven Global Fund aid management model, which is country led but has strong fiduciary risk management
- > potential synergies to the Government of Indonesia of bringing two HSS funding streams in alignment with national priorities

- > complementarity of AusAID support for human resources and health financing with Global Fund support for health information systems and pharmaceutical supply chain management
- > the potential for AusAID to influence implementation of Global Fund support and leverage greater outcomes. This is particularly important because of AusAID's support to the Global Fund globally as well as in Indonesia through the Debt2Health program.

The key risks of this harmonisation are seen to be:

- > the Global Fund's slow grant disbursement record, which limits the impact of its funding
- > Indonesia becoming tainted by international allegations of the misuse of Global Fund grants (real or perceived misuse)
- > increased transaction costs for AusAID staff for policy dialogue and managing key national-level relationships—aid coordination always takes more time than envisaged
- > the tendency of countries to develop parallel management, planning and reporting structures to implement Global Fund programs and meet Global Fund reporting requirements.

AusAID, the Ministry of Health and the Global Fund agreed that the partial harmonisation approach should bring benefits and can minimise the risks. The risk of parallel structures is addressed in Section 3: Implementation arrangements.

2.5 Estimated program budget and timing

Table 1 provides an estimate of budget breakdown by the program's five outputs.

Table 1: Budget breakdown by outputs, 2011–12 to 2015–16, in \$'000

	2011–12	2012–13	2013–14	2014–15	2015–16	Total	%
Output 1	500	1,000	1,000	1,000	800	4,300	9
Outputs 2 and 3	500	3,000	8,000	10,000	8,400	29,900	61
Output 4	100	500	500	500	400	2,000	4
Output 5	200	500	500	500	400	2,100	4
Monitoring and evaluation	500	500	600	600	600	2,800	6
Subtotal: outputs and monitoring and evaluation	1,800	5,500	10,600	12,600	10,600	41,100	84
Management (national, provincial, district)	90	275	530	630	530	2,055	4
ISP technical assistance and management	500	1,000	1,000	1,000	800	4,300	9
Program Technical Specialist	300	300	300	300	300	1,500	3
Local Funds Agent costs	100	80	80	100	100	460	1
Subtotal: technical assistance and management	990	1,655	1,910	2,030	1,730	8,315	17
Totals	2,790	7,155	12,510	14,630	12,330	49,415	100
	6%	14%	25%	30%	25%	100%	

Note: Percentages do not add up to 100 because of rounding.

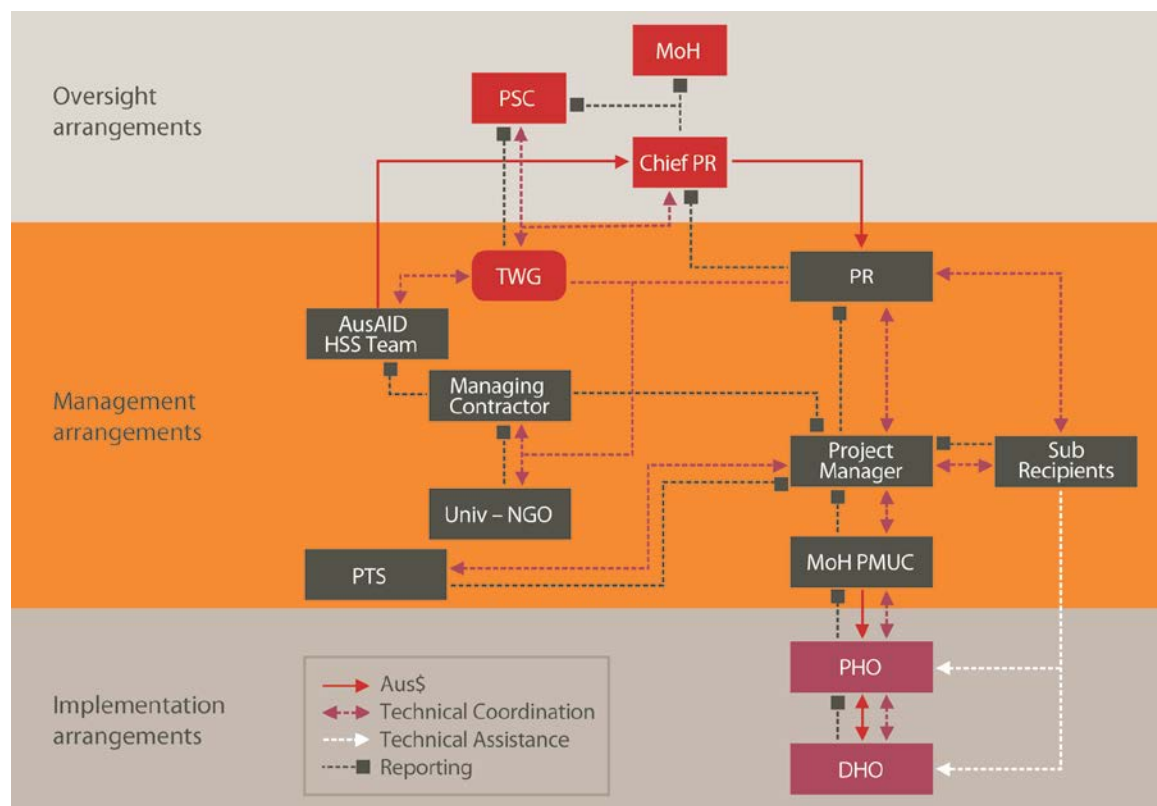
It is expected that \$40.05 million will be managed through a national PMU, up to \$7.4 million will be managed through the ISP, and the remainder will cover the costs of the Program Technical Specialist and the Local Funds Agent.

3 Implementation arrangements

3.1 Management and governance arrangements and structure

The AIPHSS program will be partially harmonised with the Global Fund HSS grant. Harmonisation will allow the Ministry of Health to achieve better outcomes more efficiently because both programs will work together. The strengths and risks of this approach are set out in Annex 7. The two programs will share governance and implementation arrangements but will have separate management arrangements. The AusAID program will be delivered by a PMU within the Ministry of Health, with support from an AusAID-contracted ISP and a Program Technical Specialist. Figure 1 shows the program's governance, management and implementation arrangements.

Figure 1: Governance, management and implementation arrangements



PSC = Program Steering Committee; MoH = Ministry of Health; PR = Principal Recipient; TWG = Technical Working Group ; HSS = health systems strengthening; Univ – NGO = university or non-government organisation ; PTS = Program Technical Specialist; PMUC = Program Management Unit (central level); PHO = provincial health office; DHO = district health office.

It should be noted that there will not be separate provincial and district-level PMU structures because the responsibility for grant management will be within the provincial and district health offices.

The governance and management arrangements were designed to ensure joint accountability between the Government of Indonesia and AusAID, and to ensure that lead accountability for managing and implementing the project lies with the PMU in the Ministry of Health.

AusAID and the Global Fund will share two oversight mechanisms. First, the Chief Principal Recipient will be the same for both donor funds, and will have responsibility to report directly to the Minister of Health. Second, a joint AusAID – Global Fund HSS Technical Working Group will provide technical oversight of both programs. In addition, there will be a Program Steering Committee with AusAID, the Ministry of Health, and other ministries (the National Development Planning Agency, the Ministry of Finance, the Ministry of Home Affairs, and provincial and district-level representation). The committee will have responsibility for setting the program’s strategic direction and for monitoring progress. It should ensure that the HSS program is contributing to improving the effectiveness of national programs. It is anticipated that the committee will meet twice a year, possibly more in the first year.

In the Ministry of Health, there will be separate management arrangements for the AusAID and Global Fund programs because each program has its own technical issues. The Principal Recipient and PMU for the AIPHSS program will be within the Bureau of Planning and Budgeting. The PMU will be responsible for developing, managing, implementing and reporting on annual work plans; convening the working group; overseeing the ISP and the Health Policy Network; and putting in place a clear monitoring and evaluation plan (see Annex 7 for full responsibilities). AusAID will provide funds for staff in the PMU. There will be very close cooperation between the PMU for AIPHSS and that of the Global Fund HSS grant, and their respective offices may be co-located. There will be separate bank accounts. The PMU will be led by a national program manager who reports to the Program Steering Committee. In line with the Government of Indonesia’s commitment to bureaucratic reform, the Ministry of Health has undertaken a review of salary structures. It is expected that Global Fund incentive payments will be phased out within the Ministry once the new arrangements are in place. The Global Fund and AusAID support the phasing out of incentives.

The Ministry of Health and AusAID want to ensure that the program does not result in unsustainable parallel management, planning and reporting structures and systems that increase transaction costs on country staff. At the national level, the PMU will be part of the Bureau of Planning and Budgeting in the Ministry of Health. At the provincial and district level, staff contracted to administer the AusAID program will be integrated within provincial and district health offices. The format, timing and process of developing work plans will be integrated with national planning processes, and the Ministry of Health will be encouraged to integrate Global Fund HSS processes with AIPHSS if this is not already the case. However, it is important to ensure that approval of work plans and disbursement of funds to provinces and districts are not subject to the same delays within the Indonesian system as have been experienced by some Global Fund grants.

AusAID will contract a Program Technical Specialist to work in the PMU to provide senior-level expertise to the program manager. The specialist’s role will be to provide high-level technical inputs on health systems and health policy, and to assist the program manager in overall program coordination. The Program Technical Specialist will be accountable to the PMU, will report to the PMU manager and will not represent AusAID views or positions. AusAID will also contract the Global Fund’s Local Fund Agent to

perform the same level of programmatic and financial oversight that it undertakes for Global Fund grants in Indonesia.

AusAID will contract an ISP to provide technical assistance, training and capacity building to the national PMU and provincial and district health offices. Training and capacity building will be based on national, provincial and district demand, and prioritisation will be led by the Ministry of Health and the PMU. The ISP will also be responsible for managing and contracting the Health Policy Network and the Civil Society Challenge Fund. The ISP manager will report contractually to AusAID and operationally to the PMU and the Program Steering Committee. The ISP will develop annual work plans with the PMU so that they are demand led and respond to program needs. The ISP will submit annual work plans and annual reports to the PMU for sign-off and to the Program Steering Committee (including AusAID) for formal approval.

The PMU manager is expected to convene a monthly meeting with the Program Technical Specialist, the ISP manager and the Monitoring and Evaluation Adviser to ensure coordination among their activities.

3.2 Implementation plan

Program implementation will begin in 2011 and continue until June 2016. An inception period will run from the time the program is approved until early 2012 when the PMU and ISP are operational. The outline implementation plan is at Annex 10. The inception period will include critical activities to get the project operational as soon as possible, and to maintain the positive momentum of Ministry of Health – AusAID program design discussions. Activities will include any additional fiduciary risk assessment; establishing the PMU and recruiting staff; contracting the ISP; formulating the first work plan of activities (for the period 1 July 2012 – 31 December 2013); agreeing indicators, baselines, milestones and targets for the logical framework; and collection of necessary baseline data.

3.3 Monitoring and evaluation plan

A monitoring and evaluation plan will be developed during the inception phase and will be based on the Logical Framework, and an evaluability assessment. The inception phase will include activities to finalise the Logical Framework, including agreement on the indicators, targets, baselines and milestones. During this period the available data sources will be assessed and a work plan of activities will be developed to build capacity to strengthen national routine health information systems or surveys. An impact evaluation for the program will be designed during the inception phase. AusAID will recruit a Monitoring and Evaluation Adviser to support the Ministry of Health with inception activities and to work in the PMU. The adviser will be novated into the ISP contract once the contract is established.

3.4 Procurement arrangements

Program design does not envisage large Ministry of Health–led procurement processes. Procurement will mostly be of services, including technical advice and research, which adheres to standard Government of Indonesia procurement processes. The fiduciary risk

assessment of the PMU (within the Ministry of Health's Bureau of Planning and Budgeting) will include assessment of contracting and tendering systems and capacity.

3.5 Sustainability

There are three key elements to the sustainability of the AIPHSS program:

- > ensuring that funding of health service delivery from national and district budgets is sustained
- > sustaining improved planning by districts and service delivery by Puskesmas
- > sustaining the demand for, generation of, and use of evidence for making pro-poor health policies.

The sustainability of funding of health services should be possible because AusAID funding for actual health service delivery will be almost zero (but may include a few small grants to encourage innovation) and will be minimal compared with existing government funding for health services for poor people. The Government of Indonesia has the fiscal space to continue to increase health service funding, and appears to have the political will to do so.

Sustaining improved health planning by districts and health service delivery is a key challenge that program activities will need to address and plan for from the outset. In particular, the practice of *mutasi* is a particular risk to future sustainability. The program will need a strong focus on institutional capacity building that involves considerations beyond knowledge and skills. Districts will be selected carefully to identify those where there is strong political will to improve health care for poor people and to strengthen the capacity of the district health office.

The third element of sustainability is the use of evidence for making health policies that benefit the poor. A key strategy for the program is to create demand for and ownership of such evidence through funding and technical assistance to the Ministry of Health and district health offices to commission research and use the results. The program will invest in building the capacity of researchers to provide relevant evidence in accessible formats to policy-makers.

The program will influence policy by improving administrative datasets and systems, including those that involve the transfer of information from the districts to the national level. It will support both the technical aspects (that is, high-quality data) and the 'softer' processes (that is, advocacy, leadership and new mechanisms to incorporate evidence into policy) related to evidence-based policy, planning and budget decision making.

3.6 Overarching policy issues (gender, anti-corruption and the environment)

Gender

Significant gender-related issues affect the achievement of the program outcome. First, quality sex-disaggregated data on health status and health care use is essential for program and health system planning. Second, women and men face considerably different health issues, which require different planning at the district and primary health

care levels. Those issues explain the focus of this health systems program on supporting improved maternal health outcomes. Surveys have demonstrated gender-related concerns for women accessing health services. In addition, women working in the health system face gender-related barriers to enjoying a safe workplace free from the fear of violence, and equal employment and promotion opportunities. The program will develop a gender action plan in its first six months to identify, prioritise and implement activities to address the identified gender issues. The Ministry of Health nominated a gender focal point, who will assist in implementing and monitoring the action plan. The focal point will be involved in the development of strategies to increase the capacity of Ministry personnel and the integration of gender equity into all planning activities. A gender assessment was conducted to inform the design of the program; see Annex 4.

Anti-corruption

The Government of Indonesia recognises the risks posed by corruption. The three main risks of corruption in Indonesia are:

- > collusion and kickbacks in procurement processes
- > collusion in recruitment of staff
- > misuse of funds for inappropriate activities, activities not undertaken or false accounting.

The program modality includes clear arrangements for managing fiduciary risk and ensuring sound financial management (see Annexes 5 and 7). The program modality was selected and designed specifically to minimise fiduciary risk while maximising national leadership and ownership. PricewaterhouseCoopers, the Global Fund's Local Fund Agent, will be contracted to provide fiduciary oversight of the program. AusAID will work with the Ministry of Health to identify a mechanism to deal with allegations of the misuse of funds with the Ministry should such allegations arise.

Environment

The main environmental risk is unsafe disposal of contaminated medical waste at health facilities. The program will ensure that Ministry of Health standards for safe disposal of medical waste are adhered to in all program-supported facilities. The program complies with the *Environment Protection and Biodiversity Conservation Act 1999*.

3.7 Compliance with the *Financial Management and Accountability Act 1997*

The AIPHSS program will comply with the *Financial Management and Accountability Act 1997*.

3.8 Business case regarding imprest account

There will not be an imprest account.

3.9 Critical risks and risk management strategies

The program is ambitious, but the risks (including sustaining long-term government support for reform and alignment with the Global Fund mechanisms) are manageable. The program combines sophisticated, sustained engagement and a strong mix of technical, strategic aid effectiveness and management skills in the AusAID team; strong links with other AusAID programs in the areas of social protection, economic governance and decentralised public financial management and in the knowledge sector; and a robust and effective Program Steering Committee. Therefore, AusAID considers that the overall risk rating for the program is medium. Table 2 outlines the seven ‘high’ probability or high-impact risks and some of the risk management strategies. See Annex 12 for a detailed outline of risks and risk management measures.

Table 2: Risks and risk management strategies

	Risk	Probability	Impact	Comments and risk management strategies
General risks	There are reports of misuse or wastage of Ministry of Health funds.	High	High	<ul style="list-style-type: none"> > Ringfencing of AusAID funds to avoid contamination. > Identification of a mechanism to deal with allegations of funds misuse with the Ministry of Health.
	Government commitment to financing universal coverage and strengthening health systems is not sustained.	Low	High	<ul style="list-style-type: none"> > Selection of districts uses criteria of local commitment to health and health systems strengthening. > Program supports research and evidence to advocate for sustained health funding for the poor.
	National policy-making processes do not use evidence from research and health systems programs in districts to inform future policies and policy implementation.	Medium	Medium	<ul style="list-style-type: none"> > Program works to create demand for evidence and to improve the supply by increasing the quality, relevance and accessibility of the evidence. > Program develops a communications strategy which involves multiple channels of disseminating evidence including health officials, researchers, civil society, parliamentarians, and the media. > Program also supports advocacy of evidence from different levels of government, civil society to decision-makers.
Program-specific risks	Mutasi at district level (in particular) limits the potential for technical assistance and training to lead to sustainable improvements in health planning, budgeting and service delivery.	High	High	<ul style="list-style-type: none"> > Capacity building and technical assistance develop systems and skills in offices and individuals. > Program operates in a sufficient number of districts to spread risk so that at least significant majority unlikely to suffer serious mutasi. > Program identifies options for managing the risk of mutasi and advocating for policy changes.
	Program Management Unit does not increase national ownership.	Low	High	<ul style="list-style-type: none"> > AusAID ensures all elements of strategic decision-making are conducted jointly. > Clear description of roles and responsibilities of Program Management Unit and its accountability with the Ministry of Health are agreed at program outset.
	There are reports of misuse or wastage of AusAID or Global Fund HSS funds in Indonesia.	Med	High	<ul style="list-style-type: none"> > Comprehensive fiduciary risk assessment. > Clear agreement on financial management rules and controls at program outset in the program implementation manual. > Contingency plan developed to freeze and recover assets if required. > Agreement with Global Fund on expectations and ways of working. > Contingency plan for alternative funding arrangements should Global Fund mechanism fail

Risk	Probability	Impact	Comments and risk management strategies
			<ul style="list-style-type: none"> > Semi-annual verification of implementation and annual on-site data verification conducted by the Local Fund Agent. > Annual audit.
National-level oversight of provinces and districts is weak.	Medium	Medium	<ul style="list-style-type: none"> > Oversight and monitoring arrangements agreed at outset to ensure national involvement. > Program designed to link to national Ministry of Health interests and thereby increase stake on program success.
Capacity in district health offices remains weak.	Medium	High	<ul style="list-style-type: none"> > Program develops framework for assessing capacity of district health offices and uses this to monitor capacity development and raise alarm if insufficient progress is evident.
Universities and civil society develop poor-quality research and provide poor-quality technical assistance.	Low	Low	<ul style="list-style-type: none"> > AusAID-contracted resource facility provides technical assistance to university and civil society researchers in research and in presenting findings in accessible format for policy-makers.
Risks of diluting policy dialogue if Global Fund presence and influence is greater.	Low	Low	<ul style="list-style-type: none"> > Program Steering Committee is AusAID-specific oversight mechanism providing high-level forum for dialogue. > AusAID has strong in-country presence and will coordinate with Global Fund including through Country Coordinating Mechanism.
Program leadership of different components is uncoordinated.	Low	Medium	<ul style="list-style-type: none"> > Program management team comprising managers of each key component meets monthly with terms of reference to coordinate. > Program Steering Committee terms of reference include oversight to ensure all program components are contributing to the shared outcome.
The absorptive capacity of the Program Management Unit (at all levels if they are established) or of provincial and district health offices is limited.	Medium	High	<ul style="list-style-type: none"> > Technical oversight on quality of Program Management Unit provided by Program Technical Specialist. > Program Management Unit staff are employed for provincial and district health offices.
Changes in the political economy across the sector (across all levels of government and legislature).	Low to medium	High	<ul style="list-style-type: none"> > Stronger links between MoH and AusAID delivered through the program enable changes to be anticipated and the program to adapt accordingly. > Fallback options include shift in program emphasis from national to subnational or vice versa. > Program Steering Committee to develop criteria for pull back from areas where the program is not progressing. > At subnational level, alignment with Australia–Indonesia Partnership for Decentralisation provinces and districts gives additional leverage. > Presidential decree that requires all districts to give written undertakings prior to receiving program grants.
Planning processes do not result in the selection of appropriate or effective activities and as a result implementation is not effective in achieving program outcomes	Low	Medium	<ul style="list-style-type: none"> > The role of Program Technical Specialist reduces the risk and ensures that effective activities are selected for implementation. > National Program Management Unit will continue to provide significant resources to build capacity for improved data analysis, prioritisation and preparation of medium-term strategic and investment plans as a basis for annual work plans and selection of activities. > Work plans will be subject to approval by Program Steering Committee.

Risk	Probability	Impact	Comments and risk management strategies
The establishment of the Program Management Unit (mechanism) encounters delays that affect implementation.	Medium	High	<ul style="list-style-type: none"> > Clarity between AusAID and Ministry of Health on roles and responsibilities and timelines on recruitment of staff to Program Management Unit and early agreement on respective roles in recruitment of Program Management Unit staff in districts and provinces. > Close coordination between AusAID and Ministry of Health during the establishment process
Delays in negotiations and signing of subsidiary arrangement and grant agreement.	Low	High	<ul style="list-style-type: none"> > Discussions on subsidiary arrangement already commenced in June 2011 with relevant Ministry of Health directorates. > Continued close coordination between AusAID and Ministry of Health during this process.
Ineffective use of resources due to a lack of cooperation between MoH, other relevant ministries and subnational government partners.	Medium	High	<ul style="list-style-type: none"> > Program Steering Committee provides clear direction to all levels of government on program implementation and is a mechanism through which to identify issues with cooperation that affect use of resources. > Role of the Program Technical Specialist (as identified in the terms of reference) will include early identification of cooperation issues that may affect use of resources. > Role of Technical Working Group to ensure consistency between AusAID AIPHSS and Global Fund HSS programs and ensure HSS grants are aligned with Ministry of Health priorities.
Improvements in primary health care services are not recognised by poor people and there is no change to demand.	Low	Low	<ul style="list-style-type: none"> > AIPHSS program will work, where possible, in the same provinces and districts as the Australia–Indonesia Partnership for Decentralisation, which has a strong focus on generating demand for health services. > Work in Vice President’s office to better target Jamkesmas to lower two income quintiles. > PNPMM Generasi Conditional Cash Transfers to be rolled out nationally from 2012.

The national PMU will develop a risk register in the first six months of the program for approval by the Program Steering Committee. The risk register will outline the risks, the level of probability, potential impact, and risk management strategies. It will be updated biannually to monitor risks, identify emerging risks, and update risk management strategies. The Program Steering Committee might consider identifying owners of each of the risks among the steering group to give high-level leadership to risk management.

Annexes to AIPHSS program design document

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Annex 1: Health policy, health status and health systems

Introduction

This annex provides an introduction to and assessment of the health status, health systems and health policy issues in Indonesia. It outlines the key challenges and where the AIPHSS program can contribute.

This assessment has the following sections:

1. Health status in Indonesia
2. Health policy environment
3. Health financing and health systems
4. Health insurance coverage
5. Conclusion: the rationale for AusAID program and other donor support.

1 Health status in Indonesia

Health outcomes have significantly improved in Indonesia. While good progress has been made on many key indicators, there has been worryingly slow progress on improving maternal health. The total population in 2010 was 237 million.¹⁴ The fertility rate is declining and life expectancy at birth was 67 in 2010.¹⁵

MDG 4—Improving child health: Indonesia has made good progress and is on track to achieve the MDG on reducing child mortality. Under-five mortality has decreased from 97 to 44 per 1000 between 1991 and 2007.¹⁶ Infant and neonatal mortality rates are also declining and on track. Infant mortality has decreased from 68 to 34 per 1000 live births (between 1991 and 2007) and neonatal mortality from 32 to 19 per 1000 live births in the same time.¹⁷ However, immunisation coverage is low for a middle-income country, at 77 per cent (Cambodia and Vietnam are both above 90 per cent)¹⁸ and stunting is high in children under five, at 40 per cent in 2000–2009.¹⁹

MDG 5—Improving maternal health: Indonesia requires a considerable effort to reduce its maternal mortality rate. Progress has been slow and maternal mortality is particularly high (228 per 100 000 live births) in 2007.²⁰ This is far short of its MDG target of 102, and much worse than Vietnam (64 per 100 000) and Philippines (with a

¹⁴ 2010 Population Census, BPS, quoted in 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', BAPPENAS 2010.

¹⁵ WHO, World Health Statistics 2010.

¹⁶ BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.

¹⁷ Ibid.

¹⁸ The Lancet Series on South East Asia

¹⁹ WHO, World Health Statistics 2010.

²⁰ BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.

similar GNI per capita) (84 compared per 100 000).²¹ Skilled birth attendance increased considerably, from 43 to 73 per cent between 1992 and 2009.²² Antenatal care is increasing. Completion of four antenatal care visits is relatively high regionally (81.5 per cent in 2007, compared to 74 per cent in Thailand and 78 per cent in Philippines) but still not sufficient. There continues to be unmet need for family planning, which requires further attention.²³

MDG 6—Tackling HIV/AIDS and other infectious diseases: Indonesia is struggling to make progress addressing HIV/AIDS, is on-track for malaria, and has already met its tuberculosis MDG targets. HIV prevalence was 0.2 per cent in 2009.²⁴ Condom use at last high-risk sex is low (10.3 per cent for women and 18.4 per cent for men in 2007) and access to treatment remains low (38.4 per cent of population with advanced HIV infection in 2009). Tuberculosis case detection has increased considerably to 93 per cent (in 2009) and incidence and prevalence rates dropped.

Other non-communicable diseases: Non-communicable diseases are rising, resulting in an increasing double burden of disease. The mortality rate for non-communicable diseases was 690 per 100 000 in 2004, compared with 272 for communicable diseases.²⁵ There are some high risk factors—smoking prevalence is very high among adult men (61.7 per cent in 2006) and among male adolescents (41 per cent).²⁶

These national figures on health status mask geographic, gender and income inequalities in health outcomes, which are discussed in the other relevant annexes. In summary, Indonesia has made good progress on improving the health of its population but a few challenges remain.

2 Health policy environment

Government commitment to health

The Government of Indonesia is increasing public funding for health care and is committed to achieving universal coverage, after years of under-investment in the health system. Government commitment to meeting the health MDGs is articulated in the Roadmap to Accelerate Achievement of the MDGs in Indonesia and is exemplified by rising expenditure and policy initiatives to improve health outcomes.

Increased government commitment to health is demonstrated by the rising public health expenditures (see Figure A1.1).

²¹ The Lancet Series on South East Asia

²² BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.

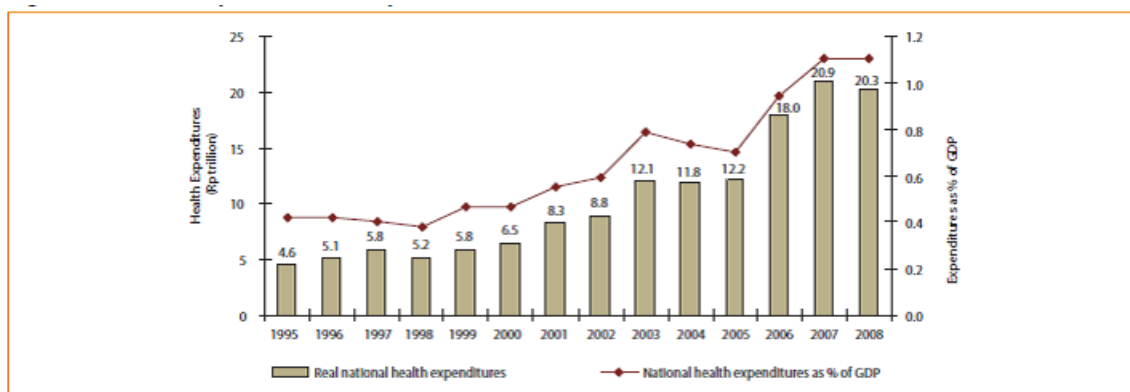
²³ BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.

²⁴ Ibid

²⁵ WHO, World Health Statistics 2010

²⁶ WHO, World Health Statistics 2010

Figure A1.1: Trend in public health expenditures, 1995–2008



Source: World Bank staff calculations, based on data from MoF.
Note: At constant 2000 Rupiah prices.

The government has introduced new health financing channels to improve coverage, including the Jamkesmas (the result of a reform of the former Askeskin) to provide coverage for poor people; the BOK (discussed below) in 2010 to fund operating costs of primary health care centres; and the Jampersal to make antenatal care and safe deliveries free.

The government is also passing and enacting laws to improve health care. The Social Security Law No. 40/2004 mandates a universal social health insurance scheme to reach universal coverage. Although it has not yet been implemented, it appears that there is still commitment to achieving universal coverage; the key question is how. In 2009 the Health Law No. 36 made it a requirement that 5 per cent of the national budget and 10 per cent of district budgets be allocated to health. The Ministry of Health’s Strategic Plan (Renstra) 2010–2014 outlines the key policy objectives and priority interventions for the health sector. The plan does not give a strong sense of prioritisation, and it is not supported by a costed budget.

A major challenge for the government is the implementation of new policies in a highly decentralised context. Many districts have not yet developed the capacity to plan and manage their health budgets, to identify local health needs and to set targets and monitor progress.²⁷ They are constrained by the existence of multiple funding channels with different reporting requirements; a slow budget approval process, which means that the first resource disbursement often occurs halfway through the year; and the centralised control over human worker regulations and placements. In many instances, the government is not seeking assistance to make new or better policies, but to support implementation and refining of existing pro-poor policies.

Other factors contributing to improved health care

Water and sanitation coverage has increased between 1990 and 2008 but still needs improvement. The population using improved drinking water sources was 80 per cent in 2008, but in rural areas was 71 (89 in urban areas). Improvement in sanitation coverage was significantly lower at 52 per cent overall, but only 36 per cent in rural areas.²⁸ The Roadmap notes that ‘Special attention is required to achieve the MDG targets for Goal 7 by 2015’.²⁹ Australian assistance to the water and sanitation sector aims to provide safe

²⁷ World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

²⁸ WHO, World Health Statistics 2010.

²⁹ BAPPENAS ‘A Roadmap to Accelerate Achievement of the MDGs in Indonesia’, 2010.

water to 970 000 people and basic sanitation to 860 000. Through the Australia–Indonesia Water Hibah program, Australian assistance is helping to operationalise and fund a successful pilot program involving output-based financing with 35 local governments. Australia has provided \$20 million in funding to the pilot program to provide household water connections to 76 000 homes and to reform the water sector.

Indonesia has also made good progress on addressing other key determinants for health: overall literacy rates and female education. Indonesia is on track to achieve goals for primary education enrolment rates and literacy rates, and has already met or is making progress towards eliminating gender disparity in primary and secondary education.

The Government of Indonesia has made good progress in extending access to nine years of basic education to all children. However, around one-third of 13- to 15- year-old children are still not enrolled in junior secondary school because schools are too remote or too expensive or the schools they can access are of poor quality.

In recognition of the continuing challenges relating to education access and quality, Australia, through a new \$500 million Education Partnership, will support Indonesia to improve learning outcomes through school construction; professional development training for principals, supervisors, district and provincial education officials; improvement of the learning environment of Islamic schools; and strengthened policy research.

3 Health financing and health systems

Indonesia has made considerable progress in building a national health system but is now facing some difficult challenges to continue progress to achieving universal coverage. A particular challenge is the stewardship, financing and management of a health care system in a highly decentralised country where districts are assuming new responsibilities for health care funding and management but lack the capacity to effectively discharge those responsibilities. This section examines key health systems issues, including health financing, human resources, infrastructure and pharmaceuticals, and then concludes by returning to the issue of decentralisation.

Health financing

Total expenditure on health as a percentage of GDP has increased from 2 to 2.2 per cent in between 2000 and 2007. There has been a relatively even split between public and private health care, but in recent years the proportion of health expenditure from the government has begun to increase. Government expenditure as a proportion of total health expenditure increased from 36.6 to 54.5 per cent in the same period, while private expenditure on health care decreased from 63.4 to 45.5 per cent of total health expenditure.³⁰ General government expenditure on health as a percentage of total government expenditure is low compared to that of other comparable countries, but increased from 4.5 per cent in 2000 to 6.2 per cent in 2007 (less than Philippines, 6.7 per cent, and Vietnam, 8.7 per cent).³¹ According to government legislation mandating decentralisation, districts should allocate 10 per cent of their budget for health, but the

³⁰ WHO, World Health Statistics 2010

³¹ WHO, World Health Statistics 2010

evidence suggests that many districts, particularly poor ones, fail to reach this target. Overall health expenditure in Indonesia per capita is comparatively low at \$81, compared with \$130 for Philippines (Table A1.1).

Table A1.1: Regional comparison of key health expenditure data³²

	THE (% GDP)	GGHE (% THE)*	Private health expenditure (% of THE)*	GGHE (% government expenditure)	External (% of THE)	SHI (% THE)	Out-of-pocket (% THE)	THE (per capita US\$)	THE (per capita PPP Int\$)
Malaysia	4.4	44.4	55.6	6.9	0.0	0.4	40.7	307.2	604.4
Thailand	3.7	73.2	26.8	13.1	0.3	7.1	19.2	136.5	285.7
Philippines	3.9	34.7	65.3	6.7	1.3	7.7	54.7	62.6	130.2
Indonesia	2.2	54.5	45.5	6.2	1.7	8.7	30.1	41.8	81.0
Vietnam	7.1	39.3	60.7	8.7	1.6	12.7	54.8	58.3	182.7
Laos	4.0	18.9	81.1	3.7	14.5	2.3	61.7	26.9	83.9
Cambodia	5.9	29.0	71.0	11.2	16.4	0.0	60.1	36.8	108.1
Low income	5.3	41.9	58.1	8.7	17.5	4.6	48.3	26.8	67.0
Lower middle income	4.3	42.4	57.6	7.9	1.0	15.8	52.1	80.2	181.0
Upper middle income	6.4	55.2	44.8	9.4	0.2	21.0	30.9	487.9	757.0
High income	11.2	61.3	38.7	17.2	0.0	25.6	14.0	4405.2	4145.0
Global	9.7	59.6	40.4	15.4	0.2	24.6	17.7	802.3	862.5

Data from the World Health Statistics, 2010.³³ In accordance with National Health Accounts conventions, external finance is included within government and private shares (which sum to 100%). Private health expenditure includes out-of-pocket payments, private social insurance, and other private insurance. International dollars are used when comparing across countries. US dollars are used when looking specifically in one country. THE–total health expenditure. GGHE–general government health expenditure. SHI–social health insurance. PPP–purchasing power parity. Int\$–international dollar. NA–not available.

Table 2: Key indicators of health financing in seven countries in southeast Asia in 2007

In addition to historically insufficient health funding, health in Indonesia is further complicated by the fragmented health funding streams from the national level to the districts and health service providers, including Puskesmas, the key primary health care provider. Health funding is fragmented into the following key national funding channels:

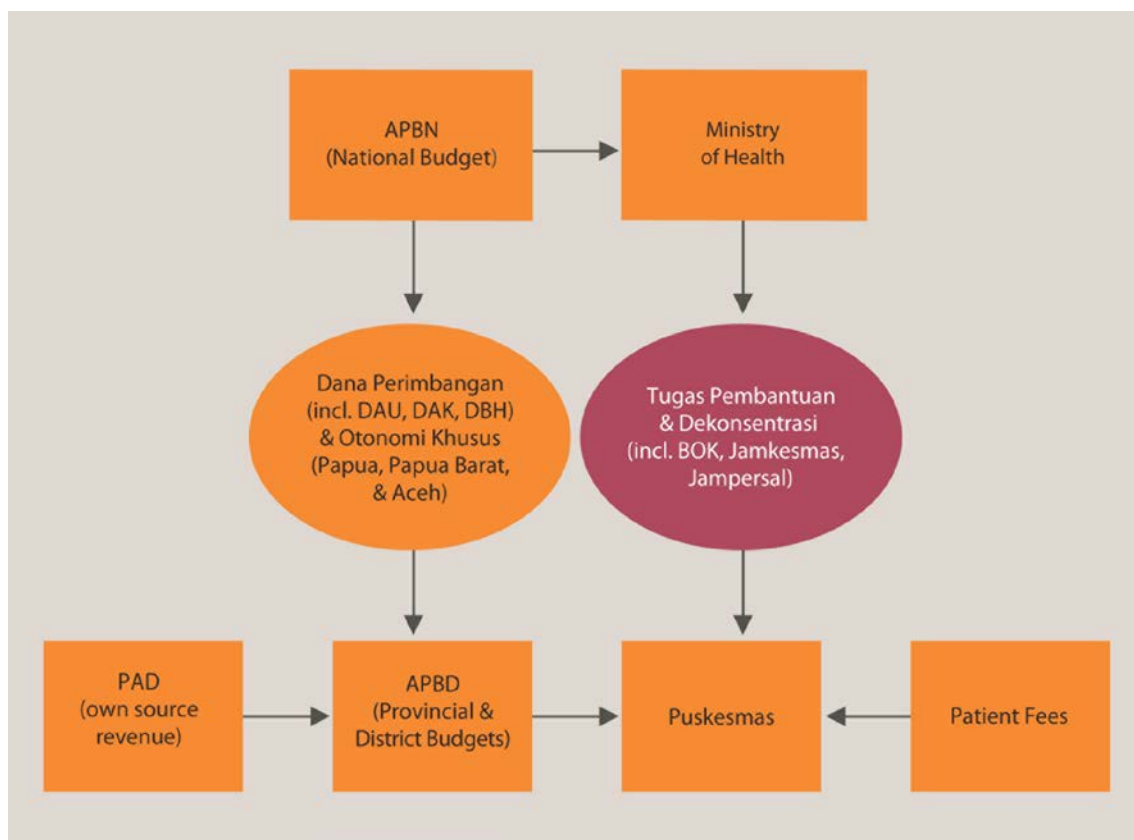
1. National to subnational transfers occur through the national government consolidated budget and district government consolidated budget process.
2. Jamkesmas, public health insurance for poor people administered at the Puskesmas level, funds activities and is a subsidy to enable poor people to access free services.
3. Bantuan Operasional Kesehatan (BOK), introduced in 2010, funds operational costs for Puskesmas for preventive care and health promotion.
4. Jampersal, introduced in 2011, funds free maternal care and delivery for mothers in health facilities.

In 2008, 42 per cent of public health expenditure came from the national government, 15 per cent from provinces and 43 per cent from districts.³³ These proportions were fairly constant since 2001, but there was an increase in the proportion from the national government, a decrease from the provincial level, and a slight increase from the district level. Direct national government financing for health facilities through BOK and Jamkesmas is the largest source of funding for maternal and neonatal activities at the primary health care level. Each of these funding streams has different administrative requirements (Figure A1.2). The complex annual planning and budget approval cycle, requiring a hierarchy of parliamentary approvals from district level up to national level, results in a long delay in approval of plans and, therefore, in disbursing government funding. It is not unusual for districts and health facilities to receive their first annual tranche of funding in June or July. This has an impact on the effectiveness and efficiency of health resource utilisation. There are current discussions in government about merging or streamlining BOK, Jamkesmas and Jampersal to reduce transaction costs.

³² The Lancet South East Asia Series drawn from World Health Statistics 2010. Data is for 2007.

³³ World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008

Figure A1.2: Simplified diagram of funds flows to Puskesmas



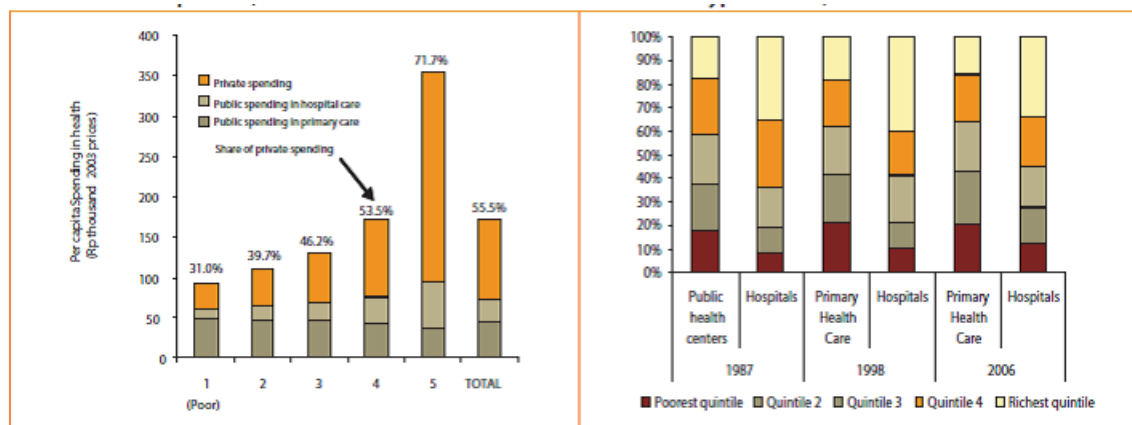
APBN = Anggaran Pendapatan dan Belanja Negara; DAU = Dana Alokasi Umum; DAK = Dana Alokasi Khusus; DBH = Dana Bagi Hasil
 BOK = Bantuan Operasional Kesehatan; PAD = Pendapatan Asli Daerah; APBD = .Anggaran Pendapat Belanja Daerah
 Source: AusAID working document.

Health care financing is fragmented and characterised by slow disbursement. It does not benefit the poor as much as national policy intentions would suggest. The World Bank estimates that the majority of spending is channelled into secondary care, and that the poor benefit much more from primary care than secondary care.³⁴ Data indicate that in 2008, the ratio of primary health care funding to hospital funding for the poor was 1:3.6.³⁵ Figure A1.3 shows that the wealthiest quintile benefit more from public funding for hospitals, and Figure A1.4 shows that poor people utilise primary health care more than hospitals.

³⁴ World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

³⁵ Hasbullah Thabrany undated presentation non Indonesia's Health System.

Figure A1.3 (left): Benefit incidence of spending (public and private); Figure A1.4 (right): Healthcare utilisation by quintile and type of care, 1987–2006



Source: World Bank staff calculations.

Source: World Bank, 2007c, updated with Susenas, 2006.

As noted above, private health expenditure is high and makes up a considerable proportion of total health expenditure. Out-of-pocket expenditures for health care in Indonesia have traditionally been high and are one of the key equity issues in the health sector in Indonesia. The proportion of household expenditure on health decreased to 2.8 per cent in 2006.³⁶ In 2007, 66.2 per cent of private health spending on health care was out of pocket, and private health expenditure was 45 per cent of total health expenditure.³⁷ The World Bank estimates that in 2007 private health expenditure was 65 per cent of total health expenditure and that out-of-pocket expenditures constituted 74 per cent of private health expenditure.³⁸ This is higher than the WHO estimate and implies that 48 per cent of total health expenditure was out of pocket. This is a considerable financial barrier to care, and a potential cause of impoverishment. Catastrophic health expenditure has been declining, but 0.9 per cent of the population was impoverished as a result of health care costs in 2006, a substantial number of people given Indonesia's then-population of 230 million.³⁹

Health infrastructure

Indonesia has a mixed public and private health care delivery system. The public health system expanded significantly in the 1970s and 1980s and by 2005 Indonesia had 7700 Puskesmas with 22 000 health subcentres.⁴⁰ Figure A1.5 shows the components of the Indonesian public health delivery system. The private health sector has seen a significant expansion of private hospitals and private hospital beds, which almost doubled between 1990 and 2005 to 626 hospitals and 52 300 beds, equalling the number of public-sector beds.⁴¹ The total number of beds per person is increasing but is still significantly lower than in other Southeast Asian countries.

³⁶ World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

³⁷ WHO, World Health Statistics, 2010.

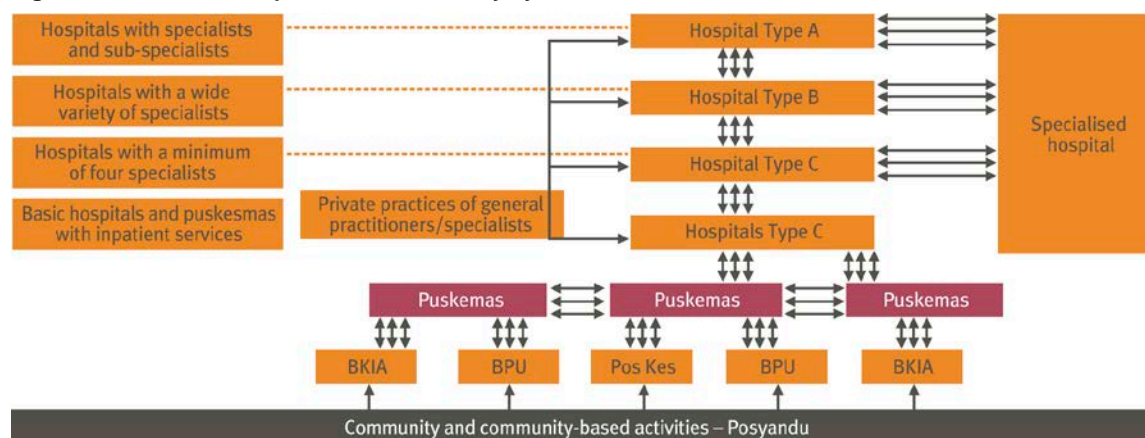
³⁸ World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

Figure A1.5: Indonesian public health delivery system⁴²



Puskemas are the backbone of primary health care in Indonesia. There is considerable variation in the size of populations served by the Puskemas; an average of 100 000 people are served by 3.5 Puskemas.⁴³ However, in most remote areas there is less than one Puskemas per 100 000 people.

Health workforce

Health workforce per person in Indonesia is lower than in other Southeast Asian countries (see Table A1.2).⁴⁴

Table A1.2: International comparison of health sector workforce

Country	Physicians			Nurses			Midwives		
	Number	Density per 100,000	Year	Number	Density per 100,000	Year	Number	Density per 100,000	Year
Indonesia	29,499	13	2003	135,705	62	2003	44,254	20	2003
Cambodia	2,047	16	2000	8,085	61	2000	3,040	23	2000
Thailand	22,435	37	2000	171,605	28.2	2000	872	1	2000
Vietnam	42,327	53	2001	44,539	56	2001	14,662	19	2001
Philippines	44,287	58	2000	127,595	169	2000	33,963	45	2000
India	645,825	60	2005	865,135	80	2004	506,924	47	2004
Malaysia	16,146	70	2000	31,129	135	2000	7,711	34	2000

Source: WHR, 2006.

The lack of health workers is particularly severe at the primary health care level in poor, rural and remote areas. The government has increased the supply of health workers considerably, and the number of public and private medical schools has increased. By 2008, there were 465 midwifery schools and 682 nursing schools, which produced 10 000 midwives and 34 000 nurses each year.⁴⁵ The number of doctors has risen in response to increased private practice opportunities.

Puskemas are understaffed and have an insufficient number of doctors, and many remote rural areas do not have sufficient midwives. There is also a serious question of dual

⁴² Presentation by Mulya Asmi, Direktur Bina Pelayanan Medik Spesialistik, Dirjen Yanmed on the Annual Social Obgyn Convention, Malang, 4 April 2008.

⁴³ World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

⁴⁴ Ibid.

⁴⁵ World Bank, New Insights into the Provision of Health Services in Indonesia: A Health Workforce Study, 2010.

practice: as many as 65 per cent of publically employed health staff have second jobs.⁴⁶ Absenteeism is very high, 40 per cent in primary health care centres, and high compared to other Southeast Asian countries.⁴⁷ Evidence from two districts suggests that village midwives earned as much as 58 per cent of their income from private clinical work, and only 35 per cent from publically funded clinical work.

The overall quality of the education that health workers receive is low. The World Bank analysed data from the Indonesia Family Lifestyle Survey as a proxy for quality of health care provision and health workers.⁴⁸ While not a perfect measure, the findings suggest that the quality of services has increased, but that the increase was marginal and that the overall quality is low. This includes the ability of health workers to correctly diagnose and treat key child and maternal health presentations. The quality of health professional education, particularly for midwives and nurses, is also insufficient.⁴⁹ The government recognised this and began to implement measures by introducing new accreditation standards for medical schools and requiring medical schools to meet the new standards.

Problems with the organisation and utilisation of health workers work against optimising efficiency. There are strict national controls on appointing health workers. They must be appointed as civil servants, which limits the flexibility of districts to innovate and find local solutions to the shortage or poor distribution of health workers. National government still controls all permanent and temporary civil servants, and is responsible for hiring, firing and employment conditions. District governments lack the authority to plan and manage their health workforce, but have to allocate budget for government-appointed health workers.

Pharmaceuticals⁵⁰ and corruption

According to a recent World Bank study, Indonesia has a ‘strong foundation for effective regulation of the safety and quality of medicines’. Indonesian manufacturing meets most of the country’s needs for medicines. Approximately 30 per cent of health spending in Indonesia is on medicines, equivalent to US\$12 per capita per year. Much of this is out of pocket. People are paying more than necessary because the largest proportion of medicines sold are branded generics and are sold at higher than the international reference prices. While drug quality appears to be high because of enforcement of Good Manufacturing Practice, there are questions about the lack of regulation of pharmacies and drugs stores. On the whole, availability of essential medicines in Puskesmas is quite good, but there are some regional variations due to low budgets, high transport costs and low procurement ceilings set by the Ministry of Health. There are inefficiencies in public procurement and supply chain management, exacerbated by the inefficiencies in the planning and procurement processes, and complicated by the decentralisation of responsibilities for some aspects.

⁴⁶ World Bank, Investing in Indonesia’s Health: Challenges and Opportunities for Future Public Spending, 2008.

⁴⁷ Ibid.

⁴⁸ World Bank, New Insights into the Provision of Health Services in Indonesia: A Health Workforce Study, 2010.

⁴⁹ Ibid.

⁵⁰ The information in this section draws exclusively on World Bank, Indonesia Health Sector Review: Pharmaceuticals: Why reform is needed, March 2009.

There is little clear evidence and analysis of corruption in the health sector. The possibilities that exist include:

- > incentives for large procurement contracts, including infrastructure, equipment and medical supplies
- > allocation of sought-after and limited health positions, in particular those classified as full civil servants
- > accounting for health expenditure, in particular during the end-of-year rush to realise health budgets.

Corruption is an ever-present problem. In some cases, poor policies have encouraged corruption, as has the lack of health resources. Closely related to the perpetual problem of corruption is the increasing commercialisation of politics, which can ultimately affect how governments function, for example, in determining how budgets are allocated and distributed. The need for elected representatives to recover the costs of expensive electoral campaigns once they have been elected does not bode well for the health system in its role as the provider of primary health care for the poor. The stark reality is that the provision of basic health services for the poor is not yet able to garner the same amount of votes or kick-backs as the provision of a road or shiny new piece of infrastructure.

Decentralisation and health care financing and management

National government transferred responsibility for managing and delivering health services to the people to local government at the district level. Districts have assumed responsibility for employing staff, paying salaries, managing budgets and planning services, but they do so with limited capacity to assume the new responsibilities, and are often constrained by national regulations, for example, on civil service. AusAID is supporting the Australia–Indonesia Partnership for Decentralisation to help improve district-level local government administration.

The capacity of local governments to reprioritise resources from the locally raised, discretionary budget towards health is limited by the overall volume of their funding. In addition, national health expenditure comes with mandates and restrictions that limit the flexibility for district governments to re-allocate resources.⁵¹ Local governments receive funding from multiple national sources including the Dana Alokasi Umum (General Allocation Fund) (DAU); Dana Alokasi Khusus (Special Allocation Fund) (DAK); sectoral allocations including Jamkesmas, Jampersal and BOK; and locally raised revenue. DAK and DAU funding is heavily tied to specific expenditures (for example, DAU for salaries). District governments lack the capacity to effectively manage these complex sources of funding for health. In 2006, only 73 per cent of the money allocated to health was spent.⁵² There are similar complexities in managing the health workforce, and with procuring and managing pharmaceuticals. The repercussions of a decentralisation process are still affecting the ability of districts to deliver quality health care in an efficient way.

⁵¹ World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008

⁵² Ibid.

4 Health insurance coverage

The government is committed to achieving universal coverage of health insurance. In 2005, an estimate 85.9 million people had health insurance coverage, approximately 41 per cent of the population (this assumed full coverage of the poor through Jamkesmas, which was not the case).⁵³ Almost 60 per cent of the population, therefore, does not have health insurance and is at risk of economic distress from the catastrophic cost of health care. The government is enacting a number of policies and financing streams to move towards universal coverage.

Poor people are not using health care, in particular primary health care, as much as they need, and are not benefiting sufficiently from high-quality primary health care. A number of factors explain the low utilisation of primary health care. Many poor people who are entitled to free care under the Jamkesmas scheme are not currently participating.⁵⁴ Approximately 50 per cent of health spending in 2009 was through out-of-pocket payments.⁵⁵ For the large number of poor or near-poor, such a level of payments exposes them to a substantial risk of economic distress due to the catastrophic cost of health care. In 2006, 1.2 per cent of households suffered catastrophic health expenditure (a reduction from 1.5 per cent in 2005).⁵⁶ Impoverishment as a result of health care costs also decreased slightly, from 1.2 per cent to 0.9 per cent of households between 2005 and 2006. This is still a significant number of Indonesia's population.

There are indications that government strategies to improve health coverage, in particular for the poor, are having some positive impact. The Jamkesmas health insurance scheme covers almost half the poor population (43.3 per cent), and increases the likelihood of those covered to use in-patient services.⁵⁷ Jamkesmas beneficiaries are less susceptible to catastrophic expenditure than those with no health cover at all. There are some challenges for the Jamkesmas scheme, including most significantly the non-participation of a large number of poor people who are eligible. Not all the poor benefit, and there is leakage and mismanagement.

The cost of health care is not the only factor limiting access to health care. Geographical access and proximity to health care are problems in many remote parts and smaller islands of Indonesia. Many of the interventions required to improve child and maternal health require effective primary health care for immunisation, antenatal care leading to safe delivery, and integrated child health. There are indications that poor people often avoid primary health care because of a perception (which may be valid in some cases) that the quality of care available is not high quality and that they are better off making their out-of-pocket payments elsewhere. Health workers in primary health care facilities (Puskesmas) often do not have the necessary skills, or do not see a sufficient number of cases to maintain a high level of skill and experience in managing complications. Many Puskesmas do not have the staff they need, including doctors, nurses and midwives.

⁵³ Ibid.

⁵⁴ World Bank, Indonesia Health Sector Review: Does Jamkesmas Protect the Population from Health Expenditure Shocks? 2011

⁵⁵ National Health Accounts

⁵⁶ World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

⁵⁷ World Bank, Indonesia Health Sector Review: Does Jamkesmas Protect the Population from Health Expenditure Shocks? 2011

5 Conclusion: the rationale for AusAID program and other donor support

The analysis above provides the key points for the rationale for a program of AusAID support for health systems strengthening. The key points, which are central to the theory of change (Annex 9), are:

- > Maternal health indicators are unacceptably high.
- > Immunisation coverage is unacceptably low.
- > HIV/AIDS and non-communicable diseases are increasing.
- > Poor people are paying out of pocket for health care.
- > The Jamkesmas scheme has increased coverage in recent years.
- > The Government of Indonesia is committed to achieving the health MDGs.
- > The Government of Indonesia has put in place policies to achieve universal coverage and in particular to cover the poor and improve maternal health.
- > The Government of Indonesia is increasing public funding of health care.
- > There is a positive policy environment for a donor to support government to improve the effectiveness of its national programs and funding.
- > Decentralisation is a critical issue because districts are entrusted with the responsibility to finance and manage health care, but lack the resources and the capacity to do so.
- > Health financing is fragmented and overly focused on hospital care, and disproportionately benefits wealthier quintiles.
- > Primary health care facilities in rural, remote and poor districts lack funding and qualified staff.

Other donor assistance for health in Indonesia

Donor assistance to Indonesia for health is fragmented and constitutes 1.7 per cent of total expenditure on health (2007).⁵⁸ The Global Fund to fight AIDS, Tuberculosis and Malaria is the biggest donor for health in Indonesia, where its total commitment is \$441.5 million (\$132.5 million for HIV/AIDS, \$173.6 million for tuberculosis (TB) and \$135.4 million for malaria). The Global Fund has recently approved a new Health Systems Strengthening program of up to US\$35 million over five years, which will focus support on improving health information systems and on strengthening the pharmaceutical supply chain and its management. It appears that the World Bank and the Asian Development bank may end their support for health systems development as Indonesia, now a middle-income country, is no longer eligible for World Bank International Development Association loans. The World Bank currently has a loan with the Ministry of Education to improve the training of health workers, and the Asian Development Bank has a decentralised health services program that will end shortly. The World Bank continues to play a useful role in developing high-quality analysis of the constraints and challenges facing health systems, in particular in health financing. USAID is active in supporting a program in subsectors that largely reflect AusAID's health sector investments in

⁵⁸ WHO, World Health Statistics, 2010

HIV/AIDS, maternal and child health and communicable diseases (malaria, emerging infectious diseases and neglected tropical diseases). Because the United States and Australia are the two largest bilateral donors for health, a partnership is developing between these two countries with the aim of strengthening policy dialogue with the Government of Indonesia, to ensure complementary program investments in subsectors and sharing of lessons learned. The Department for International Development (United Kingdom) is closing its support for maternal health (through the World Bank). The German Association for International Cooperation has provided support for social health insurance but is also ending this support. The performance of UN agencies in health in Indonesia is mixed. WHO, UNICEF, UNAIDS, UNFPA and FAO all play an important role in policy advocacy with government, yet where AusAID has supported their operational activities performance has been mixed. For example, AusAID's work through UNICEF on maternal and child health in Papua Province did not deliver on outcomes expected.

Annex 2: Poverty and social analysis

Introduction

This annex summarises the social and poverty analyses and the appraisal for the AIPHSS program. This analysis has the following sections:

1. Poverty in Indonesia
2. Health status of the poor and vulnerable
3. Access to health care by the poor and vulnerable
4. Policy environment for improving primary health care to benefit the poor.

1 Poverty in Indonesia

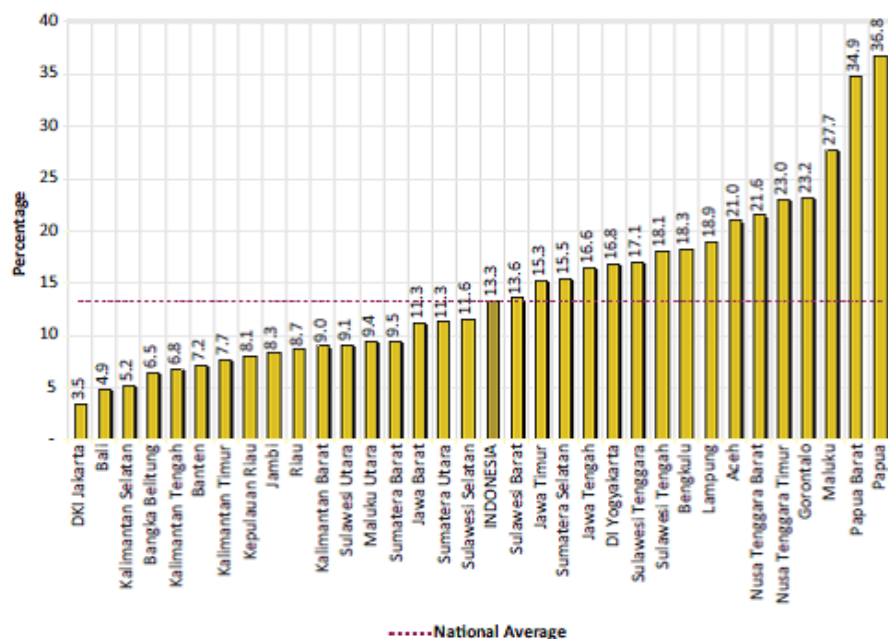
Indonesia has made great progress in reducing poverty and has already met the MDG target of halving the proportion of people with income of less than \$1 per day. In 2008, 5.9 per cent of Indonesia's population was living on less than \$1 per day.⁵⁹ In 2010, 13.3 per cent of the population lived below the national poverty line, or 31 million people.⁶⁰ This represents a considerable number of poor people. In addition to the number of poor people, a very large number of Indonesians are just above the poverty line, living on less than \$2 per day, and are extremely vulnerable to poverty. In 2006, 49 per cent of the population lived on less than \$2 per day, representing 108 million people. The World Bank suggests that 'there is little that distinguishes the poor from the near-poor'.⁶¹

Figure A2.1: Percentage of population below the national poverty line by province, 2010

⁵⁹ BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010

⁶⁰ BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010

⁶¹ World Bank, Making the New Indonesia Work for the Poor (Overview), 2006



Source: BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010.

In such a large and geographically diverse and remote country with thousands of islands, it is not surprising that there are serious disparities in income and poverty incidence between different provinces, as demonstrated in Figure A2.1. In addition, poverty is higher in rural areas, at 16.56 per cent in 2010 compared with 9.87 per cent in urban areas.⁶² Poverty is declining in both rural and urban areas.

In addition to the absolute numbers of poor and vulnerable and the regional disparities outlined above, the World Bank identified a third feature of poverty in Indonesia: income poverty does not fully capture poverty. Many people could be considered poor because of their lack of access to basic services and fundamental human development outcomes.⁶³

The non-income elements of poverty in Indonesia include lack of adequate consumption, education, health care and access to basic infrastructure like water and sanitation. In Indonesia, malnutrition rates are high, and maternal mortality has declined but remains excessively high for a middle-income country. These factors suggest that improving access to basic primary health services will help to improve the lives of the poor and vulnerable in Indonesia.

2 Health status of the poor and vulnerable

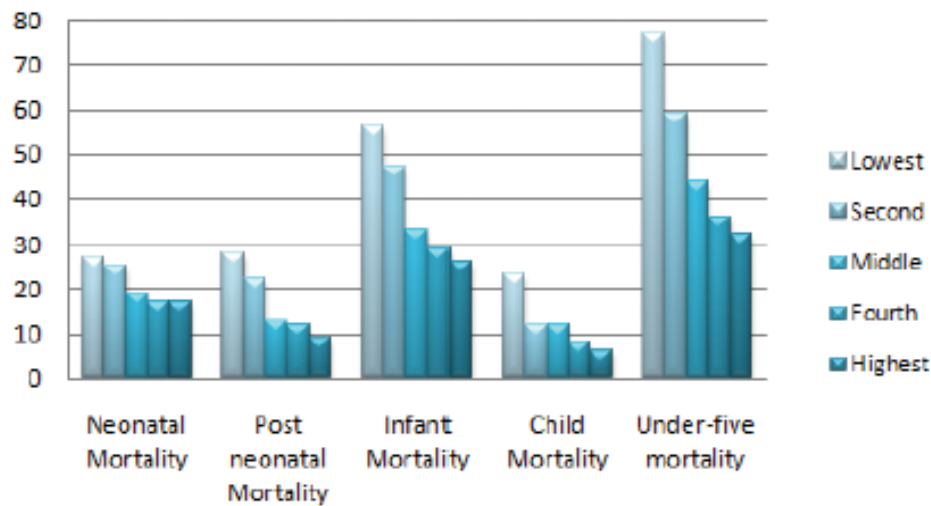
There appear to be few published studies that analyse the health status of, and health care utilisation by, the poor and near-poor in Indonesia. Such a study would be a worthwhile early investment for the AIPHSS program. However, there is evidence on health inequalities in Indonesia that suggests that income quintile, place of residence and education level of the mother are strongly associated with health status. Figure A2.2

⁶² BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010

⁶³ World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

shows that child health outcomes are worse among the poorest and most vulnerable quintiles. WHO data from 2007 shows the same picture.⁶⁴

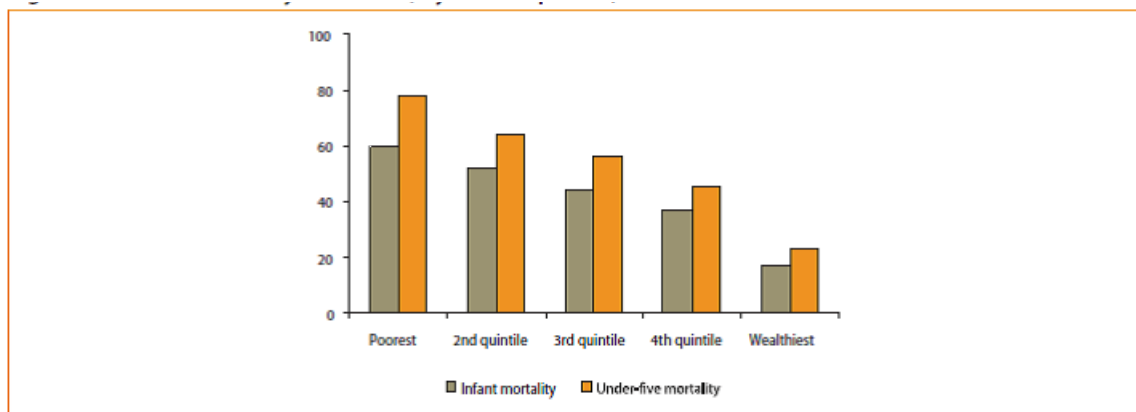
Figure A2.2: Disparities of mortality rates by wealth quintile



Source: BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010

There are also similar income quintile inequities for infant mortality and under-five mortality rates, as Figure A2.3 shows.

Figure A2.3: Infant mortality and under-five mortality rates by wealth quintile, 2002–3

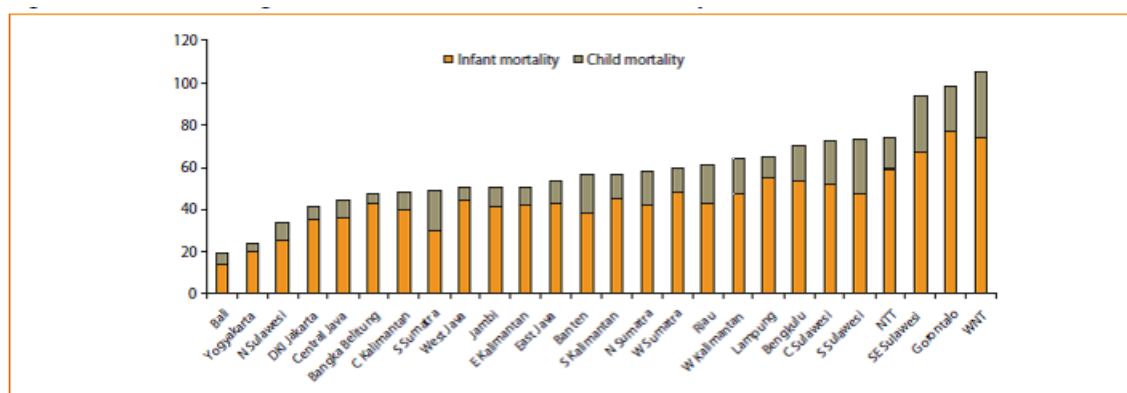


Source: IDHS 2002/03, cited in World Bank, 2007d.

There are also geographic disparities in infant and under-five mortality rates, as Figure A2.4 shows.

⁶⁴ WHO, World Health Statistics, 2010.

Figure A2.4: Differences in infant mortality and under-five mortality rates between provinces



Source: IDHS, 2002-03.

Indonesia has the third-highest burden of TB in the world, behind India and China; traditionally, poor people bear the highest burden of TB. But there is no easily readable data to confirm this.

Poor people are using critical health care for maternal and child health at lower rates than wealthier people. Table A2.1 shows levels of use, measured by skilled birth attendance and measles immunisation coverage.

Table A2.1: Coverage of key services, 2007

	Place of residence		Wealth quintile		Education level of mother	
	Rural	Urban	Lowest	Highest	Lowest	Highest
Births attended by skilled health personnel (%)	63	88	44	96	31	87
Measles immunisation coverage among 1 year olds (%)	73	82	63	85	49	83

Source: World Health Statistics 2010

The proportion of births in facilities is higher in urban areas (70.3 per cent) than in rural areas (28.9 per cent), and urban women are more likely to receive some antenatal care than rural women.⁶⁵ There are also considerable provincial disparities in the proportion of women receiving antenatal care and giving birth in facilities.

3 Access to health care by the poor and vulnerable

There is considerable evidence that demonstrates that poor and vulnerable people access health care at lower rates than wealthier people. The barriers to accessing health care include geographic remoteness, cost, lack of knowledge of entitlements under public health funding schemes, lack of knowledge about where to go and transport. Women face the additional barrier of not obtaining permission to go from the head of household or being concerned about not finding a female provider. Table A2.2 shows that for married women, the cost, distance from health facilities and the need to take transport are very significant barriers to accessing health care.

⁶⁵ BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010

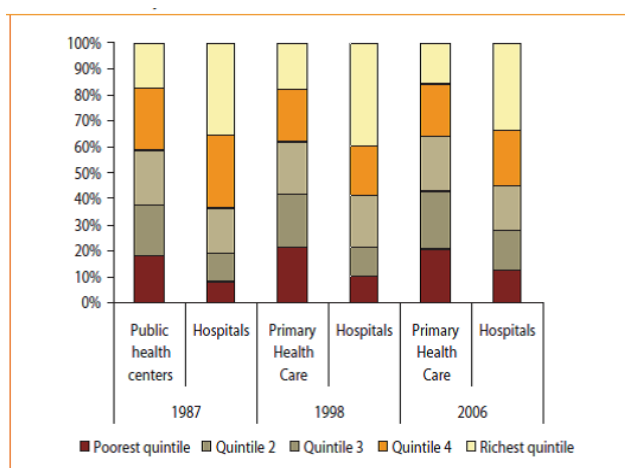
Table A2.2: Percentage of married women reporting problems accessing health care by wealth quintile

Wealth quintile	Knowing where to go	Getting permission to go	Getting money	Distance to health facility	Having to take transport	Not wanting to go alone	Concern no female provider available
Lowest	11.0	9.4	45.9	34.8	32.5	19.5	12.1
Second	5.4	4.6	30.3	19.0	16.5	12.7	10.8
Middle	4.8	3.1	23.0	11.8	9.4	10.8	10.5
Fourth	3.4	2.2	17.7	7.8	5.8	10.1	9.8
Highest	2.6	2.0	10.1	4.6	3.7	7.8	10.2

Source: Demographic Health Survey 2007

While there is not much published data on health inequities in Indonesia, there is some data on the cost of health care as a barrier to poor people and an impoverishing factor for the vulnerable. Figure A2.5 suggests that the poorest two quintiles use significantly more primary health care than they do hospital care, the inverse of the wealthiest quintiles.⁶⁶

Figure A2.5: Healthcare utilisation by wealth quintile and type of care, 1987–2006



Source: World Bank, 2007c, updated with Susenas, 2006.

Out-of-pocket expenditure for health care in Indonesia has traditionally been high and is one of the key equity issues in the health sector in Indonesia. The proportion of household expenditure on health decreased to 2.8 per cent in 2006.⁶⁷ In 2007, 66.2 per cent of private health spending on health care was out of pocket, and private health expenditure was 45 per cent of total health expenditure.⁶⁸ This means that a large proportion of health spending is made out of pocket—a considerable financial barrier to care and a potential cause of impoverishment. Catastrophic health expenditure has been declining, but 0.9 per cent of the population still became impoverished as a result of health care costs in 2006, a substantial number of people given Indonesia’s then-population of 230 million.⁶⁹

⁶⁶ World Bank, Investing in Indonesia’s Health: Challenges and Opportunities for Future Public Spending, 2008.

⁶⁷ World Bank, Investing in Indonesia’s Health: Challenges and Opportunities for Future Public Spending, 2008.

⁶⁸ WHO, World Health Statistics, 2010.

⁶⁹ World Bank, Investing in Indonesia’s Health: Challenges and Opportunities for Future Public Spending, 2008.

4 Policy environment for improving primary health care to benefit the poor

Government health and development policies

The Ministry of Health's Strategic Plan 2010–2014 includes the following mission statement:

'To reach an independent and fair healthy community pursued through the following mission:

1. To increase the degree of public health through community empowerment, including both the private sector and civil society.
2. To protect community health by insuring the availability of comprehensive, equal, quality and fair health efforts.
3. To ensure the availability and equal distribution of health resources.
4. To create good governance.'

Mission 2 and 3 refer to equity in terms of distribution and availability of health services and health resources. The strategic plan also includes a value statement that states that 'attaining the highest possible health degree for every person is one of the human rights that do not differentiate ethnic groups, religion and social economic status.'

The Presidential Instruction No. 3, 2010 on an Equitable Development Program and the Roadmap to Accelerate Achievement of the MDGs emphasise the achievement of the health MDG targets and in particular the need to prioritise maternal health. There are, however, no specific references to ensuring that the poorest benefit from achievement of improved health outcomes. There is little data in government documents on poverty, equity and health.

The World Bank identified three priority ways to fight poverty in Indonesia, among them, making services like health work better for the poor.⁷⁰ In particular, the World Bank highlights the need for better primary health care, which in turn requires better incentives for poor people to use that service and for providers to provide it. This involves reducing the financing barriers discussed above, and putting in place other key health systems strengthening measures, including ensuring that primary health care centres have qualified staff in attendance and have medicines available.

The World Bank poverty assessment identified 16 priority actions to reduce poverty in Indonesia. Four of these link to and support the outcome and outputs in the AIPHSS program:

- > 3. Invest in health with a focus on improving the quality of primary health care—public and private—and access to higher level healthcare.
- > 4. A focused effort is required to address Indonesia's shockingly high maternal mortality rate.
- > 14. Improve the poverty focus of national planning and budgeting for service delivery.
- > 16. Strengthen poverty monitoring and assessments of poverty programs.⁷¹

⁷⁰ World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

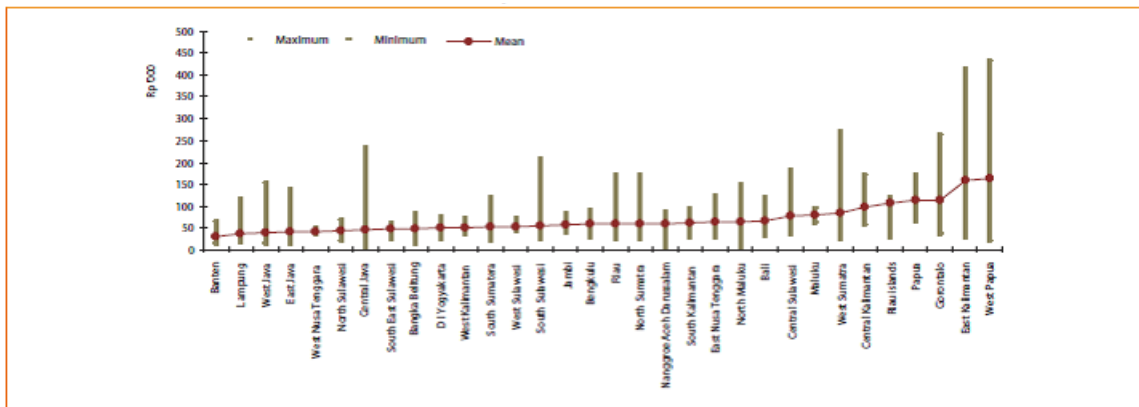
⁷¹ World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

The Government of Indonesia's health strategy does not provide a clear analysis of health status by income quintile or of poor people's utilisation of and payment for health care. There is some analysis of this in the World Bank Public Expenditure review that this annex draws heavily on for its data. However, there are gaps, and there is a clear role for this program to support the generation and analysis of evidence on the interaction between poverty, equity and health care in Indonesia.

Allocation of health resources

According to the World Bank 'the level of health expenditure varies considerably between regions in Indonesia' and 'district public expenditures for health are, as expected, higher for districts with larger budgets and higher per capita incomes.'⁷² (See Figure A2.6.)

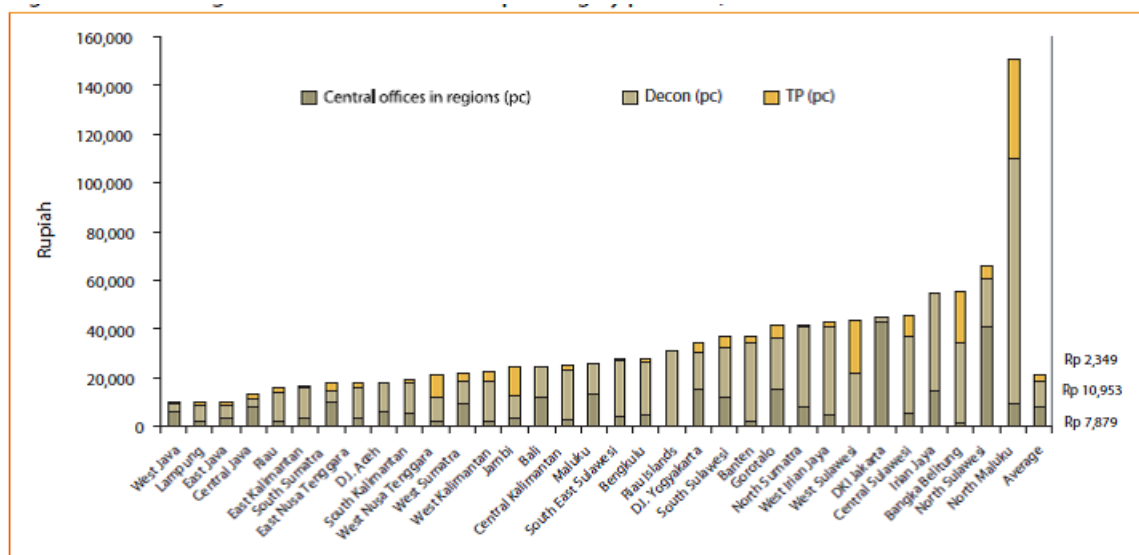
Figure A2.6: District public health expenditure by province, 2005



Source: World Bank, SIKD database, based on data from MoF.

According to the World Bank analysis, the national government expenditure per capita to the eastern regions 'is more than double that of the west' (see Figure A2.7).

Figure A2.7: National government health sector spending by province, 2006



Source: MoH, Bureau of Planning, 2007.

⁷² World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

Health budget realisation—the disbursement of the health budget—is reportedly slow across many sectors, not just the health sector. The World Bank estimated that 73 per cent of the Ministry of Health budget was spent in 2006,⁷³ and reported that in any year expenditure starts slowly and accelerates towards the end of the year. This pattern of spending occurs because the slow planning and budgeting process requires draft budgets to go through many rounds of negotiations at the district, provincial and national level before final approval.

⁷³ *Ibid.*

Annex 3: Economic analysis for the AIPHSS program

Introduction

This annex summarises the economic and financial analyses of the AIPHSS program. It outlines the economic case for AusAID to invest in strengthening the health system in Indonesia, with particular reference to primary health care.

This assessment has the following sections:

1. Economic analysis—the economic case for investing in health systems strengthening, including the cost to the country of ill health and inefficiencies in the health system
2. Financial analysis—a financial analysis of the AIPHSS program’s effect on the health sector, including the program’s sustainability
3. Fiscal impact analysis—the fiscal impact, including an analysis of how additional costs can be financed.

Since the budget for the AIPHSS program remains indicative, it is not possible to undertake a comprehensive numerical analysis. Instead, a case is presented based on the proposed outputs and activities provided in other sections of the report.

1 Economic analysis

Economic analysis focuses on the overall costs and benefits to the population as a whole. The emphasis is on whether the interventions suggested can be regarded as cost-effective in terms of the expected benefits per dollar spent compared to alternative uses for the same resources. In the absence of good local evidence, an economic analysis frequently uses international evidence on cost-effectiveness.

The AIPHSS program has both a general and specific focus. The general focus is on strengthening the health system with the aim of improving access to underserved groups. Maternal health is often seen as a ‘tracer’ of the entire health system because provision of basic and comprehensive maternal health care requires the effective operation of most health system functions (skilled and available human resources, blood banking, referral, drug procurement and supply, functional equipment) (Parkhurst, Penn-Kekana et al. 2005). For that reason, the AIPHSS program specifically emphasises improving maternal and neonatal health (MNH) service provision to directly address maternal health indicators that have persistently fallen short of national and international targets.

There are compelling social and economic reasons for investing in MNH. Globally, the case to invest remains strong: there are more than 300 000 maternal deaths per year, most preventable and largely confined to the developing world (Hogan, Foreman et al. 2010). The very low level of deaths in economically advanced countries and even in low-income countries such as Sri Lanka that have placed an emphasis on improved system access is

evidence that many of these deaths are preventable. A sick child, sick mother or maternal death places enormous emotional and economic stress on a household. Studies have suggested that maternal, neonatal and infant health problems, such as nutrition-related illness, have a substantial impact on health that continues well into adulthood (Victora, Adair et al. 2008).

The Government of Indonesia recognises that greater effort is required to meet MDG targets to reduce maternal mortality by 2015 (BAPPENAS 2010). Modelled estimates based on national survey data suggest that while there has been a fall in the maternal mortality rate since the late 1990s, the levels are not much lower than they were in the early 1990s; statistically, there may have been little change in the rate for more than 20 years.⁷⁴ This is despite substantial emphasis on improving access to skilled midwifery care, such as placement of village midwives, dating back more than 20 years (Shiffman 2003). Evidence suggests that while these initiatives have improved access and reduced inequalities in access to professional attendance at birth, the gap in access to potentially life-saving emergency care, which requires a fully functional referral system, not only trained birth attenders, actually widened (Hatt, Stanton et al. 2007). The limitations of the home-based model of childbirth and persistent difficulties for women in reaching properly equipped facilities staffed by health workers with the requisite skills are seen as major impediments to implementing substantial improvements in maternal health status (Ronsmans, Scott et al. 2009). The high level of severe maternal complications recorded in hospitals is thought to be indicative of substantial delays experienced by women in accessing good-quality obstetric services (Adisasmita, Deviany et al. 2008).

There is good regional evidence, based on international clinical studies, that while investment in basic obstetric care has substantial benefits, the benefits are far higher if comprehensive life-saving care for women with complications is offered. Calculations from one recent study suggested that for a country group including Indonesia, more than 55 per cent of maternal deaths and 22 per cent of neonatal deaths could be averted by providing comprehensive emergency obstetric care (Acuin, Khor et al. 2011). Comprehensive care requires a focus not only on improved access to a trained birth attendant but to functional basic and referral care to deal with delivery complications and neonatal emergency.

The AIPHSS program's focus on poorer groups is supported by strong international and country evidence. Currently, the rich benefit more than the poor from public spending, particularly for comprehensive obstetric care. One study in two districts in West Java, for example, found that the richest 40 per cent of the population benefit from 65 per cent of the spending on maternal care at the hospital level (Quayyum, Ensor et al. 2007). Earlier World Bank analyses found that the top 20 per cent of the population in Indonesia accounted for only 7 per cent of infant deaths while the bottom 20 per cent accounted for 36 per cent.⁷⁵ Geographic inequalities are also apparent. Birth with a skilled assistant ranges from more than 98 per cent in rich Jakarta down to less than 43 per cent in the poor, remote province of Maluku (BAPPENAS 2010). The village midwife program has increased the number of skilled birth attendants across Indonesia but coverage remains uneven. In addition, because midwives depend on private income (largely unregulated),

⁷⁴ Modelled annex data from the Institute for Health Metrics in (Hogan, Foreman et al. 2010)

⁷⁵ Data on infant mortality downloaded from World Bank website
<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,menuPK:336998~pagePK:149018~piPK:149093~theSitePK:336992,00.html>.

they often focus on serving relatively wealthy clients (Ensor, Quayyum et al. 2008). Analyses have consistently suggested that the gains from investment in interventions targeted at poorer communities are considerable provided that the problems of effective targeting and ensuring local provision of health services can be overcome (Lori S. Ashford 2006). Critical health system weaknesses undermine this provision in many low- and middle-income countries, including Indonesia.

The AIPHSS program focuses on critical health system weaknesses and aims to:

- > improve needs-based planning and budgeting
- > improve the affordability of health care by better targeting of services
- > increase the supply of well-trained staff by improving the accreditation of nursing and midwifery training
- > increase the availability of services by improving local-level planning, resulting in improved cash flow, staff retention and stocks of essential medical items.

These focuses have the potential to improve the capability of Puskesmas and the basic health care network to deliver services that are effective at reducing the need for patients to bypass those facilities and go directly to hospitals. In addition, improvements in training should improve the recognition of signs for referral. Referral would be supported by investments in targeted transport to ensure that patients are rapidly transferred to hospital when necessary.

Three justifications for the planned inputs can be identified.

1. Spending on a system with high investment potential. A recent review suggests that Indonesia is performing at least as well as its peers in improving health, at least for children and adults (Rokx, Schieber et al. 2009). Although infant mortality in Indonesia has fallen more slowly than in other countries in the region, it is lower than expected when per capita income and amount spent on health care are taken into account. The main exception is maternal mortality, which remains high both relative to income and relative to health spending. It appears, therefore, that the country has used very limited resources effectively to improve health, but that there is still much improvement to be gained through greater investments in the sector. An assessment by the World Bank suggests that improvements in outcomes expected from additional spending are dependent on a country's institutional and organisational capability (as measured by the Country Policy and Institutional Assessments Index) (Gottret and Schieber 2006). The analysis suggests that for Indonesia, with a relatively high index, the gains in maternal outcomes from additional spending are significant (a 10 per cent increase in budget leading to a 7 per cent reduction in the maternal mortality rate). This is a major reason for the specific emphasis on the maternal mortality rate in the AIPHSS program.

2. Focus on cost-effective services. The interventions that are proposed for the AIPHSS program largely affect services that are of proven cost effectiveness. At the district and provincial levels, towards which much of the budget is targeted, the focus is on improving the functionality of facilities at the Puskesmas level and below through direct capacity enhancement and improved training of nurses and midwives to work at primary care facilities. Much of the service provision at this level is focused on diseases such as TB, Malaria, HIV/AIDS and maternal health for which there are

well-known and cost-effective preventive and curative services. Those services can mostly be provided cost effectively at the primary level, although in a minority of cases—for example, complications of pregnancy—there is a need for emergency first aid and rapid referral to hospital. The program proposes to train health centre staff, including in the observation of danger signs and the management of emergencies to ensure this vital referral function.

3. Addressing documented failures of the health system. Despite evidence of value for money, there are documented failures in the health system that prevent resources being used in an effective way (Rokx, Schieber et al. 2009, p. 71). A number of these weaknesses will be addressed through the AIPHSS program, including:

- > non-compliance with good practice protocols
- > relatively low levels of skilled human resources
- > uneven deployment and low motivation of the health workforce and dual working practice
- > lack of needs-based planning.

The weaknesses are seen to impede the provision of high-quality services in the private sector, which results in self-treatment, non-treatment and self-referral to hospital. The AIPHSS program focuses on improving the planning and budgeting of services and improving skills of staff. Studies will focus on the problems of human resources retention and motivation.

Health systems strengthening envisaged in the AIPHSS program is likely to have both health and non-health benefits for communities. Health benefits are implied by making treatment more affordable and available to local communities. The delay in reaching services reduces the probability of a good outcome, an issue that will be mitigated by increased availability of good-quality, first-line treatment services at the primary care level. The critical bottleneck of inadequate and low-quality human resources is explicitly addressed in Output 3 at the facility level and Output 4 through training of staff.

Non-health financial benefits to households are implied by reducing the financial consequences of ill health. Primary-level services are usually more affordable than hospital services and more readily available. Reducing the time to obtain treatment by providing a high-quality local service helps mitigate the cost of time away from the household for the patient and carer or attendant. More rapid treatment usually reduces the period of sickness and the time away from productive activities. For specific conditions, notably tuberculosis, effective care can only be provided close to communities because of the need to make frequent follow-up visits to receive treatment.

2 Financial analysis

Financial analysis examines the additional costs and savings directly incurred by the public health sector and other parts of government as a result of the program. A program that has a strong economic impact case can easily be undermined if the financial consequences of the activities are not properly thought through. This section aims to explain the implications for public budgets of the ongoing resource commitments implied by the program.

A useful distinction for the purposes of analysis is to divide expenditures into:

- > one-off capital or program related costs
- > recurring capital costs
- > recurrent (annual) costs.

(See Table A3.1.)

Costs in the first of these categories are generally not problematic. They are fully funded by the program: when the program ends, the costs end and there is no detrimental impact on the continued operation of the services supported by the program. Such costs could include those for program design and systems to implement the program that will not be required once the source of external funding ceases. It may include, for example, the implementation of systems required by AusAID to monitor results and spending.

The second and third categories are important in assessing whether local or national budgets can absorb the future costs implied by the program. To sustain the results of the program, the ongoing costs must be absorbed into the annual budgets of the national and local governments or individual facilities. Recurring capital costs are items that are vital to sustaining the impact of the program on health programs. Many training program costs can be placed in this category because staff may be provided with initial training during the program, and periodic investment is required beyond the program through refresher training for current staff and to train new staff. Equipment is a second area where periodic investment is required. In many programs, particularly those of development banks, equipment represents one of the main components of program spending and also generates the largest recurring cost burden to the sector. Small, well-used equipment (for example, sphygmomanometer, stethoscope, computers) require replacement every three or four years and larger equipment (for example, vehicles, autoclave), every eight or 10 years.

The final category is costs that recur on an annual basis. These may include the costs of medicines and supplies, salaries of additional staff, additional incentive payments to current staff as well as recurring administrative costs that are essential to sustaining the improved programs developed during the program years.

Programs may also introduce savings to the health system. A strengthened primary care system may, for example, reduce the need for some types of hospitalisation.

Improvements in management systems can also help reduce leakage, waste and fraud.

Table A3.1: Program financial impact, types of costs and savings

Cost	Generic examples
One-off or program-related administration	Program management training International technical assistance for program design and running Program administrators (program-specific)
Regular capital items	Equipment Training for staff
Recurrent (annual) items	Costs of medicines Salary costs Program administration (program-specific)

The total budget for the proposed program is \$49.4 million. While indicative allocations have been made for each output area, there is no detailed budget showing allocations for different inputs required to ensure these activities. The types of costs and savings

generated are implied from the detailed description of activities in Annex 6 (see Table A3.2).

Much of the focus of the support through all five outputs will be on developing capabilities to improve policy and develop better information systems, including for human resources. Spending on hardware will be modest, although some computer replacement may be required to sustain improvements in information systems. Output 4 implies some upgrading of facilities to ensure that they are able to meet new accreditation standards. This expenditure could largely be one off, although it is more likely that it will imply periodic maintenance and replacement of equipment. Similarly, Output 4 could lead to some equipment purchase to ensure that newly developed standards can be taught effectively.

The two main potential recurrent costs are likely to be training and staff.

Substantial training will occur across outputs, but particularly for the development of new systems of budget and planning at the national and local levels (Outputs 1 and 2), training for facility staff (Output 3) and training of trainers (Output 4). Knowledge will need to be updated and transferred to new staff. To some extent, these costs may be incorporated into existing training schemes by adjusting the basic training of health workers.

Many of the interventions imply that staff become more functional and effective. This inevitably means that staff also become more marketable because many of the skills they will acquire are also desirable in other sectors or in the private health subsector. Retaining and motivating skilled staff is already a major problem in the sector. The problem will become even more acute as staff skills are improved.

Table A3.2: Additional costs and savings implied by the program activities

	Indicative budget (\$ million)	%	One-off or program implementation	Recurring capital costs	Recurrent (annual) costs	Savings
Output 1	4.30	8.7%	Improvement of human resources information system; technical assistance to policy unit	Training for staff to run new human resources systems	Incentives to retain staff	
Outputs 2 and 3	29.90	60.5%	Technical assistance on planning and budgeting	Refresher training; training for new staff on systems; replacement of equipment used to manage systems	Additional payments to attract adequate staff	Reduced need for some types of hospitalisation.
Output 4	2.00	4.0%	Technical assistance to support development of standards	Updating the standards; additional equipment required to train to new standards	Additional payments to attract teaching staff; increased used of services as a consequence of improved protocols	
Output 5	2.10	4.2%	Technical assistance on Health Policy Network		Staff to maintain network and research of network	
Monitoring and evaluation	2.80	5.7%	Program monitoring and evaluation		Ongoing costs required to ensure high-quality program results.	
Other	8.32	16.8%	Management and technical assistance to program			
TOTAL	49.42	100%				

These potential additional costs must be set against system savings resulting directly from the program interventions. Improving the treatment abilities of lower-level facilities could help to reduce referrals and self-referrals for expensive hospital treatment. This has been demonstrated in the Australia–Indonesia Partnership for Maternal and Neonatal Health (AIMPNH) program, where in 2010 an estimated 370 more obstetric complications were managed in district health centres compared to 2009. Many hospital beds are currently taken up with children with severe malnutrition, diarrhoea and acute respiratory infections, conditions that could be prevented or treated within the community and in the sub-district level facility network.

Without a detailed knowledge of itemised spending, it is not possible to place an overall value on the size of the net financial impact of the program. The main focus on technical assistance and training means that the overall recurring financial burden is substantially less than for a similar spending program dominated by equipment procurement. The ongoing training and staff incentive costs, however, will need to be assessed during the program to ensure that sufficient future health budget is allocated to them. The issue of staff transfer and motivation is already included as one of the concerns for Outputs 1 and 5. Some focus

on the specific issue of retaining staff who develop capabilities during the program is perhaps merited and will be included in the anticipated program activities to improve health worker retention in remote areas and to address mutasi (the continual turnover of staff at all levels of the health system).

3 Fiscal impact analysis

Fiscal impact analysis focuses on the way in which additional costs imposed by a program can be financed to ensure that the activities can be sustained. Sustaining the interventions beyond the program period will require that additional costs are incorporated into the regular budget of government at the national, provincial or district level. This is similar to the process being undertaken on the Australia–Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) program, which plans to increase cost-sharing and sustainability in the next two years.

It appears that AIPHSS program spending is relatively modest compared to overall district public health budgets. In 2011 total public spending is around Rp 48 trillion. Based on past patterns of spending, around 44 per cent of this is spent at the district (regency and municipality) level (World Bank 2007). This implies average district budgets in 2011 of around Rp 38 billion per district (\$4.25 million). Around 61 per cent of AIPHSS program spending will be at the provincial and district levels. It is envisaged, for example, that \$100 000 will be spent in the districts in the first year, a figure that will rise to \$300 000 in subsequent years. At the provincial level, it is assumed that spending will start at \$600 000 in the first year and rise subsequently to \$900 000. This implies that AIPHSS program spending would represent around 7 per cent of the average district, and 4 per cent of the average provincial, annual budget. The Public Expenditure Review suggests, however, that around 80 per cent of spending at the district level (64 per cent in provinces) is on staffing. Assuming that this expenditure is largely immutable, additional costs arising from the program will need to be absorbed by the non-staffing budget. Even if it is assumed that only a third of costs need to be financed on an annual basis to ensure that the services are preserved, this still suggests that funding amounting to around 12 per cent of the non-staff budget must be made available.

The most important source of funding to sustain the investment is likely to remain the local government budget. Primary care is largely funded by district budgets. The training of health workers and the maintenance of standards is also properly a government-funded function. Prospects to increase public funding for health are good. Economic growth remains strong despite the global economic recession (4.5 per cent in 2009 down from 6.3 per cent in 2007). Even without a reprioritisation of government spending, this should still ensure that the public health budget rises strongly: for instance, over the ten-year period 2007 to 2016, the total health budget will have risen by 65 per cent in real terms if the current proportion of total government spending is maintained. District health budgets in recent years have risen at a rate at least equal to the growth in GDP, which implies an additional resource envelope that could accommodate the additional costs. In 2006, 5.3 per cent of the total government budget was allocated to health. Countries in the region spend 10 per cent on health, while internationally many low- and middle-income African countries have committed in the Abuja Declaration to commit 15 per cent of the total government expenditure to health care. The proportion of the government budget devoted to health would only need to rise to 6.5 per cent for total spending to double over

the ten-year (2007 to 2016) period. There is, therefore, a strong basis for believing that funding from public sources can finance additional recurrent costs from the AIPHSS program provided that a good case can be made to the Ministry of Health and district administrations that the investment has had a positive impact. In the recent past the Government of Indonesia has shown a readiness to spend on programs that are seen to have a substantial impact, such as insurance for the poor (originally Askeskin, now Jamkesmas), financed out of the reduction to the fuel subsidy. This reinforces the need for a robust monitoring and evaluation framework.

Another important source of financing for the costs are the insurance funds—both public and private—that are covering an increasing proportion of the Indonesian population. Much of the focus of insurance funds has been on financing hospitals. Insurance funds have a vested interest in reducing hospital costs. One of the ways to do this is to improve the primary care network to reduce patient use of hospital-level services. The program is planning to include grants to civil society organisations to support advocacy for greater expenditure on primary health care, which will help insurance funds understand the benefits of investing in the primary care network.

The AIPHSS program is a complex program, which attempts to strengthen aspects of the health system that have the potential for substantial benefit. Financial costs beyond the program are important but appear to be manageable. There are, however, two additional fundamental issues relating to program implementation. The first relates to the generally low level of funding for the health sector and public commitment to the health system. Interventions prioritised by the program, such as improved training for health workers and better local planning, are only likely to be fully effective if accompanied by a general growth in overall health system funding. The danger is that staff are trained but continue to be inadequately resourced to carry out their tasks effectively. Overall, public funding for health care remains at a low level and there are already powerful arguments for the sector to receive a greater proportion of the national budget. Compared to other low- and middle-income countries, Indonesia spends a very low proportion of GDP on health—less than 3 per cent in total, of which 1 per cent is public funding (World Bank 2008). Regionally, total spending is closer to 4 per cent. In part, low funding is associated with underspending on the budgets allocated. The national Ministry of Finance or a local government are unlikely to provide more funding while existing budgets go untouched. The Health Public Expenditure Review, for example, documents underspending on local health budgets of 27 per cent (only 73 per cent of budgets were used) (World Bank 2008). Several activities in the AIPHSS program, particularly output 2, are focused on helping local governments to improve planning and budget capabilities. If the activities are successful, they should have a positive impact on absorptive capacity and provide strong evidence to advocate for an increase in government spending.

A second issue relates to the way in which interventions are implemented rather than in the details of itemised spending. The program is primarily about capacity and capability development. Transferring knowledge in a sustainable way requires a training model that ensures that when trained staff leave, systems are in place to permit the ready transfer of knowledge and information to other staff without requiring completely fresh investment in capacity. The precise details of how this transfer is done will depend on the details of the activity. Program activities include implementing a range of interventions to address mutasi through ensuring handovers, limiting staff turnover and developing systems that are institutionalised. It will also include, for example, development of training

capabilities in Poltekkes to ensure a sustainable supply of well-trained nurses and midwives (as already envisaged in Output 4) and modification to basic training curricula. A further issue is that local governments, faced with multiple calls on limited budgets, are likely to be more willing to devote resources from local budgets to systems that are perceived as well integrated in the existing system.

Summary

This annex provides an economic assessment of the AIPHSS program. There is strong international data on the benefits of investing in maternal health and a clear understanding of the key health systems interventions required to improve maternal health. These interventions are widely linked to broader health systems strengthening. This global understanding is supported by evidence from within Indonesia of the maternal mortality data, and an assessment of the critical health systems constraints. The program does not include a substantial load of recurrent costs. It has the potential to make savings within the health sector by improving the use of appropriate health care when needed and at the right level of health facility. Specific attention will be required to ensure that the training and capacity-building interventions are implemented in a way that institutionalises the benefits and ensures that they are not lost when people move jobs or positions. There will be some recurrent costs to sustain the gains accrued from the interventions to improve capacity. Indonesia's economic growth, current low health expenditure, and low utilisation of the existing health budget suggest that there is fiscal space for the government to invest more in health. The program aims to improve budget utilisation and the efficiency and effectiveness of existing health budgets, which should increase the likelihood of future increases in health budgets.

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Annex 4: Women's health and gender

Introduction

This annex summarises the assessment of women's health issues and challenges for the AIPHSS program in Indonesia. It includes some elements related to gender equality and inequality, as far as the very limited data permits. It outlines the key potential opportunities for the AIPHSS program to advance gender equality and address gender issues in relation to access to health care. It draws heavily on the more comprehensive gender assessment conducted in June 2010, Gender Analysis of the Health Sector for Indonesia (GAHSI), for the design of the program, and the gender strategy of the existing Australia–Indonesia Partnership for Maternal and Neonatal Health program. It does not constitute or replace a detailed gender plan or strategy for the AIPHSS program; such a plan or strategy should be part of the first annual work plan for the national Program Management Unit (PMU). An early detailed gender appraisal should cover an assessment of the core issues. While this annex suggests some initial points of focus, gender equality will be integral across all AIPHSS activities, from implementation to monitoring of outcomes.

This assessment has the following sections:

1. Research, evidence and knowledge management
2. Health status and access to primary health care of women
3. Gender and health
4. Gender, health policies, health systems planning and health systems strengthening
5. Partners for advancing gender equality in decentralised health services at the national, provincial and district levels
6. Targets, objectives, monitoring, evaluation and gender in the design and logframe
7. Gender, decision-making, participation and accountability
8. Key issues to focus on in the first six months.

1 Research, evidence and knowledge management

To address the issues and challenges of gender inequality and access to health care, it is vital to have detailed and current empirical evidence and statistical research. The GAHSI gender assessment, conducted in June 2010, highlighted the issue of the lack of gender-specific data on women's utilisation of health care and primary health care services. The ability to disaggregate the statistics on health status and health service utilisation by sex (and ideally age) when gathering information for program baselines is useful. This would help inform the assessment of the impact and outcomes by activity on both men and

women (and where possible, would be broken down to include data on boys and girls). There is very little information in the public domain on sex-disaggregated mortality, morbidity or health risk factors. Data on women's health needs across their lifecycle will be essential for planning health services. Those performing data collection will need to be mindful of Indonesia's ageing population, predicted to reach 11.37 per cent of the population by 2020.⁷⁶

The lack of detailed and comprehensive population data, including consistent civic registration, birth certificate, marriage and divorce certificates, together with a high level of fraud and falsification of identification cards, is problematic for health system planning. For example, although there is a formal system for birth registration in Indonesia, studies showed very few respondents said they had a copy of the birth certificate of their baby after delivery, either from the village head, sub-district head, or midwife (GAHSI, 2010).⁷⁷ Studies indicated that people obtain a birth certificate when they need it for school enrolment.⁷⁸ The registration system needs greater enforcement to identify trends in populations, gender differences and future health needs across the country.

2 Health status of, and access to, primary health care by women

Maternal health

Maternal health is one of the country's top priorities for the Government of Indonesia and the Ministry of Health (MoH). The current maternal mortality ratio for Indonesia is 228 maternal deaths per 100 000 live births—among the highest in East Asia.⁷⁹ Despite existing programs and interventions, the rate of reduction of maternal mortality has been slow, and the government recognises that it will be a challenge to achieve its stated Millennium Development Goal of 102 maternal deaths per 100 000 live births by 2015.⁸⁰

There are a number of possible contributory factors. Standards of working practice by skilled birth attendants are not universal and training is not always adequate to deal with complications. The MoH needs to implement universal accreditation standards for midwifery and nursing training generally. The quality of the referral system in the case of obstetric complications is often poor. Overall, numbers of midwives have increased, but many remote areas still do not have access to midwife care; more than half of trained obstetricians practice on the island of Java. There is also a distinct bias toward urban areas in maternal health care provision.

The Indonesia Making Pregnancy Safer strategy emphasised the importance of skilled birth assistance. Policies to support the strategy (for example, improving the availability of midwives through the introduction of the village midwife program in the early 1990s) have been successful in increasing skilled delivery from 36 per cent in 1987 to 73 per cent in 2007 (IDHS). However, a large percentage of women continue to give birth at home. Nearly 70 per cent of Indonesia's wealthiest women give birth with a health

⁷⁶ US Census Bureau International Database (2009)

⁷⁷ UNICEF, Gender and Poverty Study, 2008

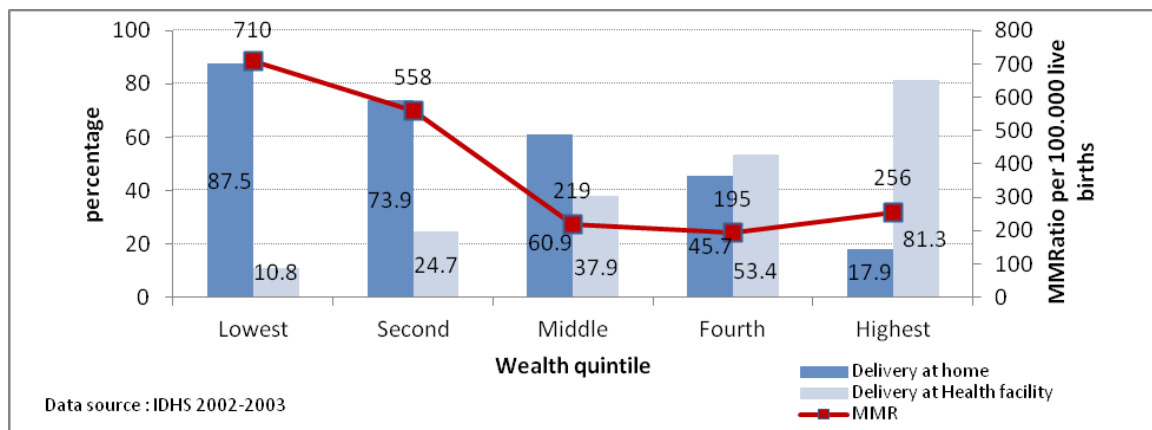
⁷⁸ UNICEF, Gender and Poverty Study, 2008

⁷⁹ Lancet, 2010

⁸⁰ World Bank "...and then she died." Indonesia Maternal Health Assessment February 2010

professional, compared to only 10 per cent of the poorest quintile in two Serang and Pandeglang districts in West Java.⁸¹ Childbirth without skilled attendants puts women at risk of delivery complications, often with unpredictable outcomes, including death. A woman's economic status, level of education and age at first marriage are all social determinants that can affect maternal health and birth outcomes. Wealth quintiles also determine what kind of health care is accessed by women, as shown in Figure A4.1.

Figure A4.1: Delivery location in relation to maternal mortality rates by wealth quintile



Complications from abortion are another major factor contributing to maternal death rates. Unmet needs in family planning contribute to unwanted pregnancy, which in turn contributes to continuing use of abortion services. It is estimated that one to two million abortions take place in Indonesia each year, and many are performed by unskilled providers in unsanitary conditions.⁸²

Neonatal health, child health and infant mortality

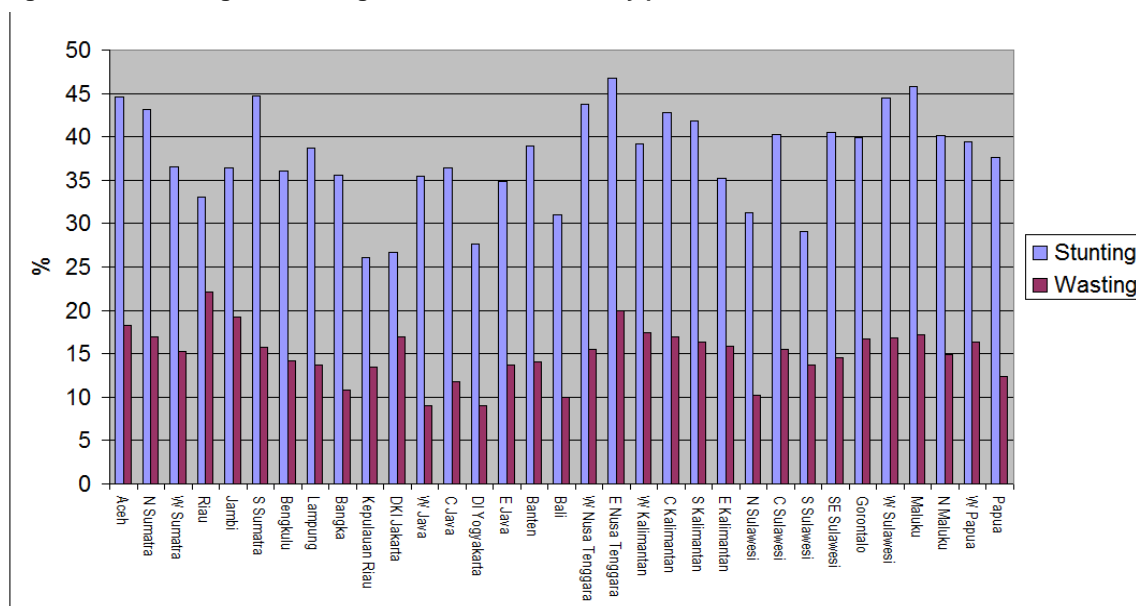
Despite reductions in malnutrition in Indonesia and the achievement of the MDGs in this area, there is still considerable maternal and child undernutrition and disparities across the provinces. A 2009 study suggested that 20 per cent of early neonatal deaths could be attributed to a lack of iron and folic acid supplementation during pregnancy.⁸³ Poor infant and child feeding practices are also affecting child health. The disparity of the nutrition status is quite wide among the regions and socio-economic levels (see Figure A4.2). The MoH Strategic Plan 2010–2014 states that in the future, the improvements for nutrition must be focused on the target groups of pregnant women and children up to the age of two and must consider the impact of physical growth, intelligence, and the productivity of future generations (WB, 2006).

⁸¹ World Bank Indonesia Maternal Health Assessment February 2010

⁸² Hull et al 2009

⁸³ Titaley C.R., M.J. Dibley, C.L. Roberts, J. Hall and K. Aghod. 2009. Iron and folic acid supplements and reduced early neonatal deaths in Indonesia. Bull World Health Organ 87: 1–23.

Figure A4.2: Stunting and wasting of children under five by province



Source: *Risikesdas*, 2007.

Behaviour change communication would help to empower mothers to improve the nutritional status of their children. Such communication could take the form of advice on breastfeeding, complementary feeding, iron supplementation during pregnancy, and Vitamin A supplementation for infants and children. This type of behaviour change communication would help reduce the numbers of mothers dependent on food supplementation to treat malnutrition in the longer term. The responsibility of fathers as male household heads should not be overlooked in terms of child survival. Improving the understanding of child health and nutrition among fathers and community decision-makers is often as important as maternal involvement in ensuring that children receive appropriate preventive and curative health care.⁸⁴

The proportion of children aged 12 to 23 months who were fully immunised by their first birthday reached 44.4 per cent in 1994, and increased to 46.9 per cent in 1997, but became stagnant after a decade.⁸⁵ Data of *Risikesdas* (primary health research) indicated a lower level of immunisation coverage among girls under two years old, compared to boys. Further studies could be done on the performance of immunisation programs and gender barriers.

Domestic violence and other social issues

Cases of violence against children, both boys and girls, are widespread in the country, and it is recognised as a significant gender issue. The Rencana Pembangunan Jangka Menengah Nasional (RPJMN) 2010–2014 (National Medium Term Development Plan) document points out that the prevalence of cases of violence against women in the country was about 3 to 4 million a year.⁸⁶ The National Commission on Anti-violence Against Women (Komnas Perempuan/KP) documented an increased number of reported

⁸⁴ UNIFEM, *Making the MDGs Work for All: Gender-responsive Rights Based Approaches to the MDGs*, UNIFEM, November 2008, pp.92.

⁸⁵ Combined data from UNICEF 2008 and RISKESDAS 2007 (2008)

⁸⁶ Data of Susenas 2006, BAPPENAS, RPJMN 2010-2014, 2010

cases of violence against women. The increase can be interpreted both as the increased confidence among women survivors to report their cases, but also the under-reporting of cases of violence against women in the past.

Cases of violence against women and children include child abuse, negligence, female genital mutilation, sexual assaults, rape and trafficking of children.⁸⁷ The 2006 National Socioeconomic Survey (Susenas 2006) indicated that about 2.29 million children experienced violence.⁸⁸ Other causes of female adult morbidity and mortality are injuries due to accidents or other ‘unexplained injuries’. The last category includes injuries that were caused by physical domestic violence that are not recorded due to the perceived privacy of such issues. More exploration of these issues and more statistical data are necessary for a better assessment of gender risks and implications.

The high number of domestic violence cases recorded in Indonesia requires a gender sensitive, multi-sectoral approach. Some cooperation exists, for example, in the development of an inter-ministerial agreement to develop and implement a minimum service standard for cases of violence against women. In addition, positive moves have been made in a recent enactment of a joint ministerial decree between the Minister of Health and the State Minister for Women’s Empowerment on Gender Responsive Programming and Budgeting, which was released in May 2010 (GASHI 2010). These are important steps forward; effective law enforcement strategies and mechanisms to protect women from gender-based violence are also vital.

The AIPHSS program can contribute by ensuring that health personnel are educated and trained about the issue of domestic violence, and know about international covenants, government policies and laws that protect women’s rights. Health workers, including nurses and midwives working most closely with women and children, can be trained to pick up on signs of abuse at routine health visits and antenatal care. They could also be given knowledge about access and referral to services for the victims of violence. The AIPHSS program can help to address this issue by ensuring that the health service promotes strong links and service integration with civil society groups and voluntary women’s support groups working in this area.

Although the new health law included mental health as one of the country’s priorities, mental health services are not sufficiently able to respond to these challenges. There are associations between gender and mental health in Indonesia. Older females and widows who have poor physical health are more likely to report worse mental health issues. Also, the male–female differential in mental health scores of Indonesia is directly related to the number of pregnancies a woman has lost, either due to abortions and miscarriages or due to child death. The AIPHSS program could play a role to address mental health problems, as the primary health care level may be appropriate for linking poor women with other services.

Barriers for women to accessing health

Issues preventing women from accessing health services include not knowing where to go, getting permission to go from the head of household, getting money needed for

⁸⁷ Data from various reports from the State Ministry for Women’s Empowerment and Child Protection, Komnas Anak, Komnas HAM, and Komnas Perempuan.

⁸⁸ State Ministry for Women’s Empowerment, Anak Korban Kekerasan (Fisik Dan Mental) Dan Perlakuan Salah (*Child Abuse*), 2009

treatment, the distance to the health facility, having to take transport, not wanting to go alone, and being concerned that there may not be a female health provider present. (See Annex 2, Table A2.2.) Key leaders have shown limited understanding of the risks of not taking into account the underlying determinants of gender inequality, and the specific socioeconomic and cultural barriers that prevent women from accessing health care services. Education and knowledge sharing at this level are vital.

HIV/AIDS—feminisation of the epidemic

Indonesia's AIDS epidemic is considered by the Global AIDS Report 2008 as 'among the fastest growing in Asia'. There were an estimated 314 500 people aged 15 to 49 living with HIV in 2009. It is estimated that without accelerated efforts, the country will have 541 700 HIV positive people by 2014.⁸⁹ Women make up about a quarter of all reported AIDS cases (GASHI 2010). Despite the increasing proportion of adult women living with HIV in Indonesia, stigma and strong gender inequalities mean that they often have difficulties in getting access to HIV prevention and treatment. Improved surveillance and information systems, including information about sexually transmitted infections among women, would help to better understand gender issues in HIV epidemics. Empowering women through the provision of knowledge of treatment and care available is also critical.

Female sex workers have a higher risk of HIV infection compared to male sex workers and yet have less access to HIV testing. In addition, the coverage of anti-retroviral treatment among HIV-positive pregnant women is very low. As of December 2009, there were an estimated 5170 HIV-positive pregnant women in Indonesia. Of that number, only 3.8 per cent received anti-retroviral treatment to reduce the risk of HIV transmission from mother to child. This shows that Prevention of Mother to Child Transmission programs are not yet well established. Identified constraints include lack of information, lack of facilities for such programs and the stigma and discrimination that HIV-positive pregnant women face when accessing health care services in hospitals, clinics and other health centres.

3 Gender and health

There is little sex-disaggregated data readily in the public domain on health status, health risk factors or health care use. It is difficult to piece together a gender-based picture of health status. The data that is available show a mixed picture. WHO provides some data that suggest that the male to female ratio of new smear-positive TB case notification is 1 to 1.4, which is the lowest (that is, most similar) in WHO's Southeast Asian Region except for Bhutan. It is lower than regional neighbours Malaysia (2.1) and Philippines (2.3).⁹⁰

Overall, cancer incidence rates in Indonesia are fairly similar for men and women according to 2010 data reported by Pfizer.⁹¹ Breast cancer is the most commonly occurring cancer among females in Indonesia (26.1 per 100 000 population) followed by uterine cervix cancer (15.7 per 100 000 population). Lung and bronchus cancer is the

⁸⁹ Ministry of Health's AIDS report, 2008

⁹⁰ World Health Organisation. Global Tuberculosis Control, WHO Report 2010.

⁹¹ Pfizer Facts: The Burden of Cancer in Asia. 2008

most commonly occurring cancer among males (20.0 per 100 000) followed by colon and rectum (11.9 per 100 000). Incidence rates for most other cancers are comparable. In addition to maternal deaths, cervical cancer and breast cancer are the top two most significant causes of early female deaths in Indonesia. It is estimated that in Indonesia, 20 women die every day due to cervical cancer.

The main lifestyle factor for which there is good-quality sex-disaggregated data is the prevalence of smoking, which shows a great disparity. Among men, 61.7 per cent over 15 years of age were reported to be smokers in 2006, compared with only 5.2 per cent of women over 15.⁹² Worryingly, there are similarly high prevalence rates of tobacco use among adolescents aged 13 to 15: 41 per cent for males and 6.2 per cent for females.

4 Gender, health policies, health systems and health systems strengthening

The National Medium Term Development Plan 2010–2014 focuses on the improvement of development outcomes and shows that the Ministry has started to develop and record gender-related outcomes of its development programs. It is expected that, by 2014, there will be an increase in the Gender Development Index according to the Ministry of Health's strategic plan (Renstra) 2010–2014.

The Ministry of Health has elaborated its gender mainstreaming strategy into some programs.⁹³ They are, among others:

- > assuring the implementation and operationalisation of gender mainstreaming at all levels of government
- > developing rigorous sex-disaggregated data
- > strengthening the legal basis of gender equality promotion in the Ministry's work
- > implementing a gender-responsive budget
- > carrying out socialisation centred on gender awareness raising.

In addition, some gender-related activities will be carried out throughout this five-year development plan, including:

- > conducting gender analysis training (Gender Analysis Pathway) in all provinces
- > improving the data base of the implementation of 'Kartu Menuju Sehat' (health development card) for children under five, by gender
- > raising awareness about stopping maternal mortality, by using stickers
- > promoting The Anti-malaria Program for Pregnant Women
- > introducing client participation for eliminating HIV/AIDS
- > aiming to win 'the Parahita Eka Praya' award in gender mainstreaming
- > increasing men's participation in contraceptive use
- > developing gender-related training modules.

The Health Management Information System is tasked with managing various health data and indicators for monitoring the Healthy Indonesia 2010, MDGs and other poverty-

⁹² World Health Organisation. World Health Statistics 2010.

⁹³ As presented in the Gender and Health's Round Table Discussions, 15 June 2010

reduction programs. Encouragement from the State Ministry for Women's Empowerment for sectoral ministries, including the Ministry of Health, to collect data that are disaggregated by sex is useful and positive, but it is not producing significant changes or results. Basic data such as those on human resources of the Ministry of Health have not been broken down by sex. Decentralisation resulted in a partial breakdown of health information systems, due to an unclear division of reporting responsibilities.

Female doctors, midwives, nurses, traditional healers, and volunteers form over half the total of health sector workers in Indonesia, and yet they lack decision-making powers. Women working as medical professionals have faced gender discrimination issues such as the lack of a decision-making voice, the lack of incentives to perform well, poor recognition for their work, restricted access to proper training and, in some cases, bias because of their gender (as women, their professionalism was undervalued). Indonesia has also had a female Minister of Health for two consecutive cabinet administrations. However, patriarchy norms and values are deep seated in health policies, planning, budgeting and regulations, as well as in the development of programming and implementation.

Further studies on the views of health workers (nurses, midwives, doctors) on their working conditions and their role in the health system would be invaluable, as would improved data on the ratios of male to female workers, including the numbers represented at decision-making levels. Data of medical school students indicated that more female students were registered than males (and completed their medical training).⁹⁴ Most of these female graduates tend to remain in urban areas on completion of their training and there is a lack of incentives to take up rural or isolated posts.

Gender budgeting in the health sector has not been put in place. While some exercises have been started, these have been focused on how to develop gender-responsive programs and to integrate gender measures into the budget formats. A summary of health spending assessments that have been carried out by national and local government would help to identify the critical gender aspects missing in terms of health financing.

The government has a number of funding schemes for priority health issues, including BOK (operating costs for primary health care), Jamkesmas (targeted funding for poor people) and Jampersal (for free maternity care). But evidence suggests that these funding channels may not be reaching front-line primary care services for the poor— including women. A study, referred to by Population Reference Bureau 2007, estimated that the cost of hospital admission for women with delivery complications is about US\$255, while the total costs to households of a normal delivery by a trained midwife was estimated at US\$51. It was reported by the study that even for a normal delivery, about one fifth of the poorest women had to borrow money to pay the US\$51. Such realities must be noted, particularly that less than a quarter of pregnant women were covered by the Askeskin program,⁹⁵ and therefore had to pay out of pocket for their delivery. Some reasons for the low coverage of the Askeskin were the low access by poor women to information about how to access and apply for the scheme.⁹⁶

⁹⁴ World Bank "Indonesia's Doctors, Midwives and Nurses: Current Stock, Increasing Needs, Future Challenges and Options", January 2009.

⁹⁵ Health insurance for the poor, Askeskin was once created in 2004.

⁹⁶ World Bank "Investing in Indonesia's Health : Challenges and Opportunities for Public Spending", 2008.

5 Partners for advancing gender equality in decentralised health services at the national, provincial and district levels

In order to work towards gender equality in health service provision, it is important that all levels of government and civil society work together. The AIPHSS program should tap into existing health and local government structures and work with existing partners at all levels. Because decentralisation shifted more authority and responsibility to local governments for health care at primary levels, focusing on key allies at this level would be beneficial.

Since the commencement of Inpres 9/200 on Gender Mainstreaming in National Development Planning and Programming, the Ministry of Health has been one of the members of the State Ministry for Women's Empowerment gender focal points. Currently, the Ministry has a gender working group to accelerate gender mainstreaming within the MoH, with focal points from the Planning Bureau, Maternal and Child Health and Community Health's Unit. The Ministry introduced a team of national facilitators for implementing gender mainstreaming in health sector development to work with the provincial level—a potentially valuable network for the program.

In many ways decisions made at the district level will have the most significant impact on women and will help address gender issues because women are the key (if not main) beneficiaries of primary health care. Puskesmas, which mainly provide basic programs and the types of services required by women and children, are key to a focus on gender in the program. Puskesmas could be a good resource for generating health information from the community. It would be useful to maximise and revitalise the work of the Puskesmas as effective and efficient service providers, and to help them act as knowledge resources on health issues, needs, and priorities that are faced by women and girls. Puskesmas can also advocate on these issues from a provincial-level perspective, feeding up to the national level. Similarly, the subnational level national planning agency (Badan Perencanaan Pembangunan Daerah (BAPPEDA)) can feed up to the national-level planning cycles. Policy and technical guidance is retained by the Ministry of Health. At the next level, health centres and hospitals provide general services. At the tertiary level there are larger hospitals and other specialised health institutions, which fit more with the wealthy demographic.

The participation of civil society, particularly women's groups, health advocates and leaders, will be important for the success of AIPHSS. Their meaningful engagement at all levels—assessment, priority setting and implementation—should be championed and their ability to bring decision-makers to account should be strengthened.

6 Targets, objectives, monitoring, evaluation and gender in the design and logframe

At the round table discussions on gender held as part of the research for the GAHSI report, some activities that could be incorporated in the AIPHSS program were identified.⁹⁷ The discussion covered the following issues:

⁹⁷ Gender and Health's Round Table Discussions, organised by AusAID, 15 June 2010

- > It is vital to meet outcomes at the service-delivery level. Activities must match the objectives. A clear set of gender objectives is the starting point.
- > Include gender indicators at all levels of the logframe.
- > Identify some key gender targets and outcomes/outputs, such as focusing on maternal and child health, immunisation, malnutrition in women and children, HIV/AIDS, TB and cancer.
- > Identify how the wider but immediate and practical needs of women and girls can be addressed by the activities, for example, domestic violence and its implications for mental health and gender welfare.
- > How can the activities work with men, men's groups and community decision-makers—their input and support is also needed for advancing gender equity.
- > Quality assurance of health care services, standardisation of practice, ethical standards and governance are critical issues in the country's health system. Targets and measurements to monitor improvements and protect women's health status are needed.
- > Adapt existing health policies and programs to respond to specific gender needs.

7 Gender, decision-making, participation and accountability

For the health sector, decentralisation offers both challenges and opportunities.⁹⁸ With their increased and accumulated revenue from the national government's transfers, local governments have increased their health sector's budget, including budget for reproductive health and nutrition improvements. However, after 10 years of decentralisation, some indications show that the local governments have not been able to fully utilise their increased budget. This is reflected in inherent inefficiencies in budget planning and budget implementation processes.⁹⁹ Also, with local governments managing 40 per cent of total public funds, the decentralisation has made corruption more visible to citizens,¹⁰⁰ who have required that local actors improve their capacity to promote good governance and accountability through the effective management of funds.

The AIPHSS program would benefit from involving women's groups in the process of planning right from the outset. Consultations with representatives from the State Ministry for Women's Empowerment, the gender working group that currently exists within the MoH, and women's organisations and civil society groups with programs or projects related to women's rights and participation in politics, governance and decision-making can all make a contribution. Gender experts and technical assistants should also be consulted in the process and their input included in the planning phase. Participatory planning exercises with key representatives from women's rights groups would help inform the planning process at each stage. Gender equality is gradually being recognised as a countrywide issue; for example, a men's organisation advocating gender equality was launched in Jakarta in March 2011. The New Men's Alliance aims to promote

⁹⁸ *Government of Indonesia / UNDP 2006–2010 Country Program Mid Term Review*, January 2009

⁹⁹ In this respect, the Government of Indonesia faces critical challenges in streamlining budget preparation and budget implementation processes of different levels of government as well as improving other critical aspects of public financial management systems and processes. While clearly more resources need to be allocated for addressing capacity issues at the local level, and greater investment levels have to be made to improve rural infrastructure, provide employment opportunities, extend outreach and upgrade the quality of public services, ensuring a systematic means for tracking implementation and implementation gaps is difficult.

¹⁰⁰ The Asia Foundation, 'Decentralization and Local Governance in Indonesia', no date.

awareness of women's rights among Indonesian men (The Jakarta Globe). Men's specific involvement in reproductive health should not be overlooked.

8 Key issues to focus on in the first six months

The first priority for the design and implementation of the AIPHSS program will be to ensure that there are activities to improve the evidence base, and information to respond to the specific needs of women, by starting with statistical research into gender-based health needs. Such research should be the basis for a gender strategy for the AIPHSS program. When looking at gender needs in terms of the utilisation of primary health care services, several key issues stand out as being the first and most urgent points of focus.

First, maternal mortality is particularly high for a middle-income country, and despite improvements in some areas, Indonesia is not reaching its MDG. This needs addressing by taking into account specific needs of poor women in rural areas. Issues such as contraception availability and abortion must also be included.

Second, high infant mortality, extensive malnutrition in mothers and children and low immunisation coverage all need to be addressed. Third, diseases such as HIV/AIDS, TB, cervical cancer and breast cancer are the greatest threats to women's lives, and therefore must be a focus of the program.

Fourth, focusing on Puskesmas and primary health care would go a long way to addressing many gender-specific issues, including those health issues which are gender related. As well as becoming effective and efficient service providers, they can become advocates and sources of invaluable sex-disaggregated health information and statistics from the community.

Fifth, women need to be given a voice in decision-making processes on the planning, delivery and monitoring of health services. Women practitioners, female politicians and public officials at the district level, and civil society women's groups should all be included. There is a particularly strong role for civil society women's groups in advocacy and in monitoring and accountability. Such a role could include advocating for more attention to health and to the health of the poorest, and poorest women, as well as monitoring health services and holding health service providers and district health offices accountable. This approach links well with the proposals for a Civil Society Challenge Fund which could have a priority theme for women's groups.

Health financing must start to address the specific needs of women. The gender working group within the MoH, together with civil society women's groups (and men's groups), should be consulted throughout the AIPHSS planning phase, to ensure that gender needs are met and are being taken seriously.

Overall, gender equality in the health sector is critical for the quality life of both women and men. The WHO defines equity in *health status* as the achievement by *all people, women and men*, of the *highest attainable* wellbeing that is possible. Equity in health care means that health resources are allocated according to need, services are received according to *need*, and the financing of the services is made according to the *ability to*

pay.¹⁰¹ Keeping gender as a consistent thread through all the AIPHSS work will help address the issues of equity in health status in Indonesia.

¹⁰¹ The Asia Foundation, "Decentralization and Local Governance in Indonesia", no date.

Annex 5: Institutional and fiduciary capacity assessment

Introduction

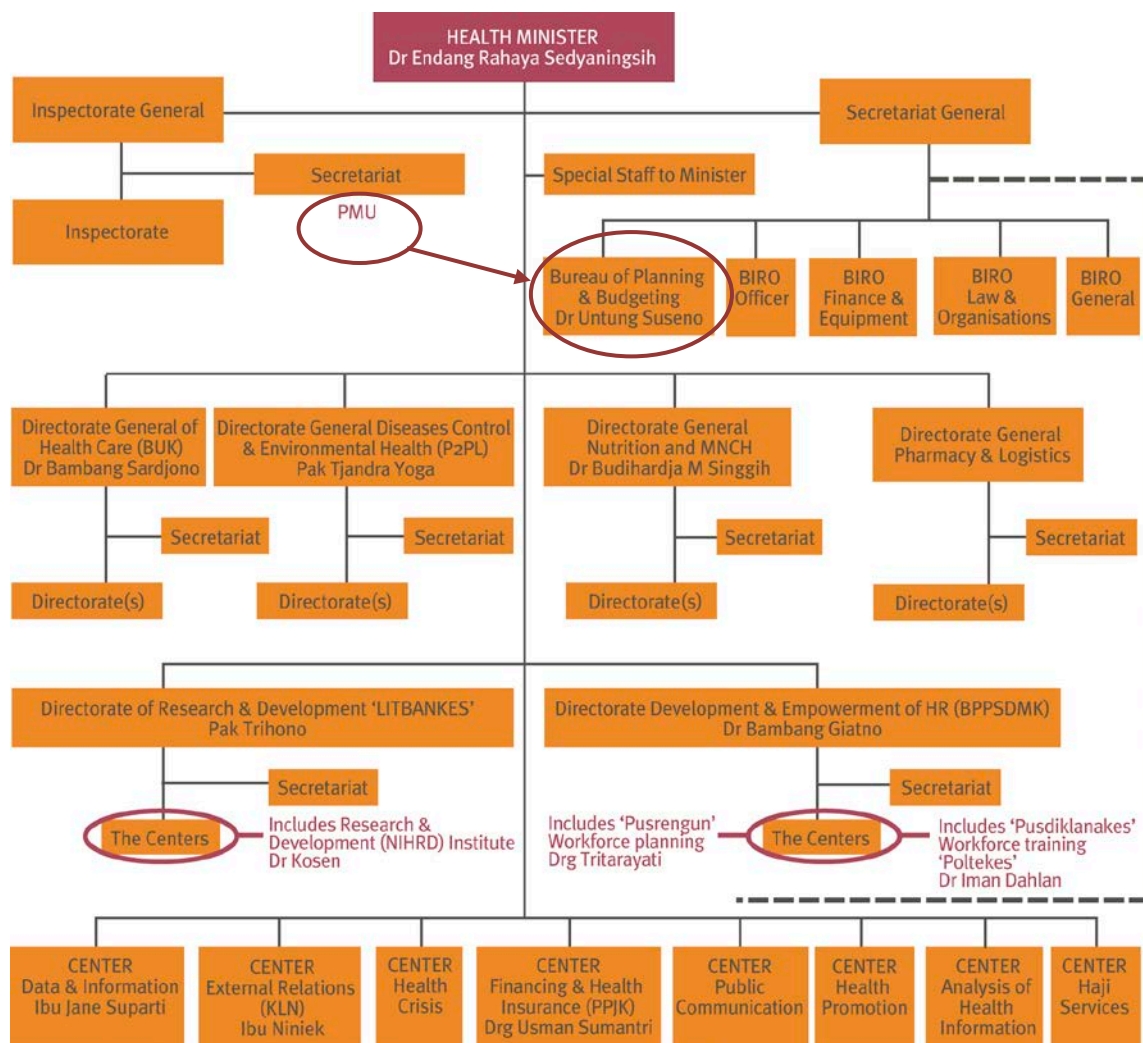
This annex summarises the institutional and fiduciary capacity of the key institutions that would have responsibility for the management or implementation of the AIPHSS program.

In particular it examines the following questions:

1. Have the most appropriate institutions been identified for the program?
2. What is the technical, financial and program management capacity of the key institutions implementing the program?
3. Are there adequate program and financial oversight mechanisms in place given the chosen modality?

1 Have the most appropriate institutions been identified for the program?

Figure A5.1: Structure of the Ministry of Health



Institutions with responsibility for program implementation

Detailed implementation arrangements can be found in Annex 7. The program will be implemented by an Implementing Service Provider (ISP) and Program Management Unit (PMU) within the Ministry of Health (MoH). The PMU will be in the Bureau of Planning and Budgeting. Ultimate responsibility for implementing and managing the program lies with the Secretary General of the MoH (as Chief Principal Recipient) and the ISP. The MoH and the ISP will receive funding from AusAID, manage implementation and report (on performance and financial matters) back to AusAID.

The program also has significant technical, program management and financial management responsibility at the provincial and district health office level (as they will receive grants from the PMU), and universities, research institutes and civil society organisations, which will receive funds from the ISP for the Health Policy Network.

Institutions with a stake in policy issues

There are a number of ministries that set policy, regulations or norms that affect health systems. These include BAPPENAS (planning and budgeting), Ministry of Finance (resource mobilisation and budget allocation), Ministry of National Education (accreditation of training institutes), and Ministry of Home Affairs (local government regulations). It is not anticipated that these national-level ministries will be responsible for managing the program, including financial management. They would be incorporated in the program governance arrangements as members of the Program Steering Committee. No further assessment of their institutional or fiduciary capacity is required.

The Ministry of Health is the most appropriate institution for delivering a health systems strengthening program. Within the Ministry, the Bureau of Planning and Budgeting PMU is best placed to provide technical oversight of the health workforce and health finance agenda. They have been extremely engaged and active counterparts during the design phase of the program. They report directly to the Chief Principal Recipient—the Secretary General—who also plays the same role in the Global Fund HSS grant.

The use of an ISP supplements the capacity of the Ministry of Health, by providing access to international technical assistance as required and capacity to manage the Health Policy Network and Civil Society Challenge Fund.

Other institutions with a stake in policy issues will be invited to participate through the Technical Working Group and Program Steering Committee (additional details in Annex 7).

2 What is the technical, financial and program management capacity of the key institutions implementing the program?

This section focuses on the three key institutions and the provincial and district health offices.

Ministry of Health (Program Management Unit)

Technical lead and appropriateness for program

The Ministry of Health will be the lead program manager. It is undoubtedly the lead government ministry with technical responsibility for the program. Within the Ministry of Health, the Principal Recipient and Program Manager will be located within the Bureau of Planning and Budgeting because the focus of the AusAID program will be on health workforce and health financing issues. The Bureau of Planning and Budget are responsible for oversight of the Ministry's budget and worked closely with AusAID in the development of this program. Their technical capacity to lead and manage this program is strong, but their capacity will be confirmed by an additional assessment to be done by the Local Funds Agent (LFA—see below for further discussion).

Program and financial management

Because AusAID plans to use the Global Fund's processes and procedures for implementing the grant to the Ministry of Health, AusAID is not required to do any additional assessments, according to the AusAID Guidelines on Working in Partner

Systems: ‘Countries in which partner government systems are (and will be) only used through other development partners do not trigger an assessment of the systems, since AusAID can rely largely on other development partners’ assessments.’

However, AusAID believes it is prudent to do some additional fiduciary checks on the Ministry. The Global Fund fiduciary risk assessment, conducted by the LFA, PricewaterhouseCoopers, focuses on the Principal Recipient within the Ministry. For the Global Fund grant, this is the Centre for Data and Information, whereas for the AIPHSS program, it is the Bureau of Planning and Budgeting.

AusAID will identify areas of the Global Fund’s assessment that are sufficient to meet its needs and also identify areas that need some additional analysis by the LFA. This work would be carried out early in 2012. Any suggested areas to be strengthened or recommendations for improvements identified in the additional LFA assessment will need to be incorporated into the grant agreement with the MoH.

We anticipate that the fiduciary processes as procedures used for the Global Fund and AusAID AIPHSS programs will be similar (that is, they are Ministry-wide rather than specific to the Principal Recipient); however, the program management capacity may differ. Therefore, possible areas for additional LFA assessment may be needed, specifically on the key management responsibilities of the PMU such as:

- > developing annual work plans and budgets
- > developing annual progress reports
- > accounting for all program funding utilised by MoH and provincial and district health management units
- > managing provincial and district health offices (program and financial management)
- > managing contracting and possible tendering for program resources
- > putting in place and implementing a clear monitoring and evaluation plan and ensuring (with assistance of others) collection of relevant baseline data. (See Annex 7 for more detail on PMU responsibilities).

Provincial and district health offices

The Global Fund HSS program will work in 128 districts throughout Indonesia. The AusAID program is planning to work in only 20. These 20 districts are a subset of the Global Fund HSS districts.

The LFA assessment tends to focus on the Principal Recipient (that is, the MoH) rather than subrecipients; however, subrecipients are assessed by the PMU, and are subject to more rigorous monitoring throughout the program.

AusAID is comfortable that the Global Fund assessments will be sufficient to cover off the institutional capacity of provincial health offices and district health offices as subrecipients.

Implementing Service Provider

The ISP will provide technical assistance, training and capacity building. The ISP will also be responsible for the establishment of the Health Policy Network and Civil Society Challenge Fund. This mechanism is favoured by both AusAID and the Ministry because of the difficulty the Ministry of Health has procuring international technical assistance

and the significant additional workload associate with managing the Health Policy Network and Civil Society Challenge Fund.

The forthcoming scope of services will specify the institutional and financial management capacity required of an ISP, and an appropriate candidate will be identified from the tendering process.

3 Are there adequate program and financial oversight mechanisms in place?

This section details financial and program oversight mechanisms that AusAID will use to safeguard its funds and ensure that the program is on track. The oversight mechanisms will only apply for funds administered by the Ministry of Health and subrecipients.

The Global Fund has a comprehensive system for financial and programmatic oversight of their grants. The LFA is a critical element in this. The LFA is the Global Fund's eyes and ears on the ground, making up for the fact that the Global Fund does not have an in-country presence. The role of the LFA is to provide both programmatic and financial oversight, consisting of:

- > assessment of the human resources and fiduciary capacity of the Principal Recipient (before signing the grant agreement)
- > semiannual program and financial audit by the LFA, known as verification of implementation
- > unannounced annual on-site verification of set of agreed indicators (mainly programmatic), known as on-site data verification
- > request for continued funding, towards the end of the second year of implementation, to determine if the grant has been performing and should be continued
- > grant close-out report that outlines outstanding assets, cash balance, etc.

In addition, there are two annual audits. The first is commissioned by the Global Fund. It is a comprehensive external audit of all Global Fund grants in a country and is carried out by a firm that is not the LFA. The second is a Government of Indonesia audit, carried out by the Indonesian Supreme Audit Institution.

Given that AusAID is planning on adopting the Global Fund implementation processes, similar oversight functions will need to be used. However, AusAID will not need to be as reliant on the LFA as the Global Fund because AusAID has an in-country presence.

Table A5.1 outlines which aspects of the Global Fund accountability mechanisms AusAID will employ for the AIPHSS program.

Table A5.1 Global Fund and AusAID accountability mechanisms

Global Fund	AusAID
Principal Recipient assessment	AusAID will make an assessment of the quality of the Global Fund LFA assessment to determine if additional investigation is required.
Semiannual program and financial audit by LFA	AusAID to commission LFA to do this for AIPHSS funds as well. Explore further with the Global Fund whether this could be done jointly.
Annual on-site verification of set of agreed indicators (mainly programmatic)	AusAID to commission LFA to do this for AIPHSS funds as well. Explore further with Global Fund whether this could be done jointly.
Two annual audits. External audit commissioned by the Global Fund, and Government of Indonesia audit, carried out by BPK	AusAID to use BPK's audit only
Request for continued funding	Not necessary
Grant close-out report	No, this is generally not required by AusAID.

These fiduciary and program arrangements are very rigorous, and the use of the LFA will provide AusAID with robust and regular information on financial and program performance of both the MoH and also subrecipients.

More details of the past performance of Global Fund grants in Indonesia and the role of the LFA can be found in Annex 7.

Annex 6: Proposed process for development, approval and review of program activities

Introduction

This annex outlines the proposed process for development approval and review of annual workplans and indicative program activities for each output in the AIPHSS program. This annex summarises the key activities that have been discussed with the Ministry of Health (MoH) as being most essential to contribute to achieving the program outputs. It draws on the health systems analysis (Annex 1) and the problem analysis (Annex 9). It also draws on the experience of the Australia–Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) because of the many common issues between the strengthening of health systems and the achievement of maternal health outcomes.

The aim of the annual work plans are to:

- > identify interventions for the program that are realistic and likely to bring about the greatest positive impact on the program output and targets
- > identify which entities will be responsible for delivering those interventions
- > identify and cost the inputs that those entities will require
- > identify indicators that will help determine the extent to which an intervention has contributed to changes in the output.

To ensure alignment with Government of Indonesia planning processes, an annual workplan will be submitted to the program’s Technical Working Group for review by the end of the first quarter of each year (March for activities to be implemented in the following calendar year). The first full year of program activities will be presented in an annual workplan developed during the inception phase and will use approval processes for the program.

The first annual workplan (July 2012–Dec 2013) will be developed in the inception phase, through a government-led process of refining and improving activities outlined in this annex. As the Program Management Unit (PMU) cannot be fully established until a grant agreement has been signed, the planning will be undertaken with the MoH and provinces with the support of technical assistance (TA) providers. Many of the capacity and needs assessments may be completed in this period with the support of TA. The first annual workplan will cover the first 18 months of program activity in the two initial provinces of East Java and NTT. During this inception phase, the development of activities and the monitoring and evaluation plan will require collaboration with the Global Fund HSS grant program rollout because it will be critical to identify to what extent the AIPHSS program can benefit from health information system development at the national and subnational level being progressed under this grant. Gaps in the health

information system that are relevant to reporting for the AIPHSS program will be identified and addressed in the AIPHSS monitoring and evaluation plan.

In following years it will be the responsibility of the PMU working with the Implementing Service Provider (ISP) to organise consultation with subnational stakeholders and develop a prioritised and budgeted annual workplan that draws on performance targets and lessons learned. The PMU will present the annual workplans to the Technical Working Group for review. These will be considered alongside a review of the implementation of the previous year's workplan. If any urgent adjustments to the current year of activities are required on the basis of the reporting, these can be agreed early in the calendar year. The timelines for annual workplan approval are mapped in Annex 10.

In its assessment, the working group will seek to ensure progress in line with agreed targets and, if required, make recommendations to the Program Steering Committee about adjustments to the program. Following technical review and recommendations from the working group, the Program Steering Committee will be requested to endorse or reject the annual workplans. The role of the program's Technical Working Group and the Program Steering Committee are set out in Annex 7.

This annex also contains indicative activities that reflect and signify a common understanding between AusAID and the Ministry of Health on the outputs that the program is intended to achieve by the end of the program, and a common understanding on the key activities and inputs required to achieve those outputs. They are indicative because a few actions are required: a more detailed needs assessment; the participation of provincial, district and Puskesmas staff in identifying needs; and a prioritisation based on the value of activities and the level of resources available. These are activities that can only be undertaken after the program has been approved by AusAID and the Ministry of Health. Our criteria for the selection of program activities for 2012–13 and beyond will be agreed with the Ministry of Health and will be formally endorsed by the Technical Working Group.

In the first instance, many of the activities will be related to research and analysis, including capacity assessments, systems overviews, assessments and reports aimed at elements of the system essential to achieving program outputs. Some of these assessments may be completed or deemed unnecessary during the inception phase (as may be the case in NTT where the AIPMNH has already undertaken significant capacity building). When required, assessment teams will include international and local health systems expertise and relevant program areas from the Ministry of Health. This will assist with improving institutional understanding and knowledge and ownership of policy recommendations, and with strengthening the feedback loops between national and subnational and service delivery levels in the health system.

Factors that will affect activity selection include the following:

- > Activities are essential and necessary to achieve outputs and targets (as agreed in the logical framework).
- > Activities are designed to address a health financing or human resources constraint to achieving program output and outcome target indicators (as agreed in the logical framework).
- > Activities build on the lessons learned from other programs, in particular AIPMNH, and demonstrate continuous improvement.

- > Activities are consistent with international evidence in health systems strengthening.
- > Activities build institutional systems and capacity.
- > Activities are not funded through other Government of Indonesia sources, although it is possible that government funding does not always deliver a timely quality product. Therefore it may be necessary to:
 - Identify if a Government of Indonesia entity is formally supposed to be providing this intervention (for example, training). If so, we should consider what factors are inhibiting the quality and delivery of this and how AusAID can address this under this intervention
 - In the case where there is no entity formally required to provide this intervention but it is needed on an ongoing basis, AusAID must consider how the program can help the government to recognise the need formally and support its establishment.

The activities presented below are grouped by Output. It should be noted that many activities required to achieve Output 3 are listed under Output 2 because the problem analysis identified critical district-level obstacles to health service performance at primary health care level.

1 Improved national decision-making

Output 1: The Ministry of Health uses evidence-based data and up-to-date information to make national-level policy decisions on health financing and health human resources to improve access to and the quality of primary health care for the poor and the near-poor.

Sub-output 1: Build the capacity of the Ministry of Health to demand and commission poverty-related research.

Contributing activities for year 1 will include:

- > capacity building and TA to undertake an institutional assessment of the evidence to the policy link within the MoH and between the Litbangkes (Directorate of Research and Development in MoH) and programs
- > training and TA provided to Litbangkes and planning, policy and program areas within the Ministry to frame research questions and to commission research, reporting and dissemination of results
- > TA support and mentoring to deliver priority policy advice on poverty-related topics linked to the output, such as streamlining health financing streams targeting poor people.

This area of activity will link with AusAID's new Knowledge Sector Program.

Sub-output 2: Key areas within the Ministry of Health use evidence to inform policy, budget and strategy documents.

Within the Ministry of Health, three key areas were identified that generate and interpret health financing and human resources data to inform policy: the Planning and Budgeting Bureau, which is responsible for preparing annual budgets, new policy proposals and forward estimates; the Centre for Health Financing and Insurance, which produces annual

health accounts (setting out income and expenditure in health, including private expenditure) and is responsible for the Jamkesmas payments systems, BOK and Jampersal; and the Centre for Health Workforce Planning, which is responsible for workforce planning and providing recommendations on requirements to the Bureau of Health Personnel, the MoH and the Ministry for the Empowerment of State Apparatus.

Contributing activities for year 1 will include:

- > TA support to conduct a needs analysis for these centres to strengthen their roles within the Ministry in generating and interpreting evidence for health policy and their capacity to advocate with other government agencies
- > assessment of key areas within the MoH that are the demand-side consumers of this data and evidence
- > development of a package of support to address capacity needs
- > support to institutionalise national health accounts
- > TA or a study to facilitate improved budgeting and higher budget utilisation rate (link with subnational level work).

Sub-output 3: Improve the information system on human resources for health.

Five key activities led by the Centre for Workforce Planning will be undertaken under this output.

Contributing activities for year 1 will include:

- > a needs assessment to identify why the current system of human resources for health information and planning is not working; identification of priority objectives of an effective human resources for health information system; and audit of key user needs. This will include data mapping to answer the following questions: what databases and information are available? Who are the consumers of the data? How is it best used?
- > development of an overview of human resources in the country, drawing on all the existing databases, to give the MoH a clear understanding for future planning and workforce training needs, including distribution of staff and dual practice
- > TA to develop strategic planning on workforce, including future mapping and analysis of effectiveness of existing workforce regulations. Activity could include planning future national training needs, impact of regulations on human resources distribution and review of existing health workforce classifications policies to see if they are adequately meeting Puskesmas staffing needs
- > support to secretariat of the cross-government Committee on Health Workforce— the multi-ministry committee that is looking at human resources across government, and possible support for some of its activities or research on issues relevant to poor people and primary health care.

Medium-term activity will include:

- > commissioning a study on the causes and implications of mutasi and developing options for addressing it (to include short-term mitigation measures and medium term policy options).

2 Improved provincial and district-level health financing and distribution of the health workforce

Output 2: Health offices in 20 districts in five provinces implement health financing and human health resources policies and programs more effectively and efficiently to improve access to and the quality of primary health care for the poor and the near-poor.

Sub-output 1: Improve the capacity of the provincial health offices (PHOs) to lead, supervise and catalyse improved district health office (DHO) management of financial and human resources.

Contributing activities for year 1 will include:

- > capacity assessment to determine priority areas for support for the PHO in its role of provincial-wide reporting on health financing, human resources and gaps
- > support for provincial-wide leadership in standard setting, policy- and decision-making, both locally and in representing the needs of the province nationally, in relation to health financing and workforce requirements, including training of health workforce at Poltekkes
- > TA and support to the PHO to address priority identified gaps and to strengthen its capacity to deliver on its role. Support may include:
 - TA and mentoring and/or facilitator to assist the PHO officials to implement the health program
 - activities to improve the availability of data and information to support evidence-based planning
 - development of TA, surveys and systems, including standards and protocols, to improve the availability of data for evidence-based planning.

Medium-term activity will include:

- > TA and support to PHO/DHO to commission studies on topics such as:
 - survey on health-seeking behaviour to understand what is required to make health services more accessible and attractive to the poor
 - survey or research on identifying who is poor and vulnerable and whether they are benefiting from national and/or district funding programs (Jamkesmas, BOK and Jampersal)
 - specific activities on gender-related issues to ensure that health services are appropriate for both women and men
 - multiple financial and workforce reporting requirements at the district and Puskesmas levels and recommendations for streamlining.

Sub-output 2: Improve systems and capacity of DHOs to make more efficient and effective use of financial and human resources.

Contributing activities for year 1 will include:

- > capacity assessment to determine priority areas for support for DHO in its role of district-wide reporting on health financing, human resources and gaps

- > district-wide leadership in standard setting, supervision of services, development of local regulations, policy- and decision-making, both locally and in representing the needs of the district to the province and nationally, in relation to health financing, workforce requirements
- > development of a package of assistance to address capacity gaps including:
 - TA to DHO for setting up district targets for health service delivery, and for individual Puskesmas targets. Support for monitoring framework for these targets, and incorporation of targets into district health annual plans
 - TA to DHO in planning and budgeting and mechanisms to report on health expenditure such as district health accounts
 - strengthening of the supervisory capacity of DHOs to monitor services and ensure that standards are maintained
 - recruitment of a facilitator to assist the DHO officials to implement the health program
 - support for training at the district level to better use health information systems and evidence to develop health plans and budgets and disburse the health budget on time.
- > assessment of referral networks and establishment of systems and mechanisms to strengthen them if required
- > district planning for coordination among Puskesmas and district health office and establishment of a coordination or working group (Pokja) to facilitate discussion with Puskesmas and PHO and DHO officials.

Medium-term activity includes:

- > demand- and supply-side assessment of health workers so that PHO and DHO officials will be able to know the number of required midwives and nurses and develop local government regulations if needed. This will also link to the capacity of the PHO and DHO for health workforce planning.

Sub-output 3: Improve the information system on human resources for health.

Contributing activities for year 1 will include:

- > reviewing current district capacity to manage and implement human resources for health policies
- > mapping the human resources situation and needs, and developing plans to address gaps.

These are linked to workforce information systems assessment in Output 1.

Medium-term activity includes:

- > TA or studies to assess issues such as dual practice to assess their impact on health service delivery.

3 Selected Puskesmas and satellite services have adequate, quality resources

Output 3: Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in 20 districts in five provinces have empowered and qualified health workers and sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor (Puskesmas achieve Poned status, that is, the management of basic emergency obstetric neonatal care).

Achievement of this output requires implementation of the activities in output 2 to address DHO-level barriers to effective and efficient use of health financial and human resources. In addition, it will require support to primary health care facilities to strengthen management systems and capacity, and to develop and implement systems to improve quality of care standards. This is a list of possible activities, but further consultation is required by the Ministry of Health with representatives from provincial and district health offices, and from primary health care providers.

Contributing activities for year 1 will include:

- > assessment of bottlenecks to improving the realisation and disbursement of health budgets and the targeting of public health funding to benefit the poorest
- > assessment of Puskesmas against agreed standards (minimum service standards, Poned—including clinical and referral—and workforce plans)
- > performance assessment of staff against job descriptions and national competencies (with a focus on nursing and midwifery)
- > commencement of training for Puskesmas managers
- > commencement of training to improve competencies of nurses and midwives.

4 Poltekkes provide nurses and midwives trained through accredited programs for selected Puskesmas

Output 4: Centre for Health Workforce Education and Training (Pusdiklatnakes) ensures selected government health polytechnics (Poltekkes) run accredited nursing and midwifery study programs (Prodi) to produce qualified nurses and midwives for the selected primary health care and village health posts.

This output reflects an investment in future quality of staffing for primary health care services.

Sub-output 1: Support the Ministry of Health to oversee and lead introduction of new accreditation standards for Poltekkes.

Contributing activities for year 1 will include:

- > needs assessment of MoH capacity to support Poltekkes to meet new accreditation standards, and of priority Poltekkes (nursing and midwifery Prodi) to determine what assistance (infrastructure and TA) they need to enable them to meet the new

accreditation standards. Focus of assessment is on needs for midwifery and nursing courses to meet new standards, as well as for the Poltekkes overall.

- > TA for a body (MoH, contracted university or other provider) to develop the tools, methodologies and experience to support MoH and Poltekkes to meet new accreditation standards. (The objective is that this body does this for the first five Poltekkes with AusAID support and then has the tools and methods for the MoH, Ministry of National Education (MONE) or Poltekkes directly to purchase their TA for rollout across all Poltekkes (Prodi)).

Sub-output 2: Support five Poltekkes to improve their nursing and midwifery training courses to meet accreditation standards.

Contributing activities for year 2 will include:

- > grants and TA to Poltekkes in five selected program provinces to implement activities to meet accreditation standards (upgrading infrastructure and TA on issues identified in needs assessments). This could be through output-based funding grants
- > demand- and supply-side assessment of Poltekkes and link to Outputs 1 and 2 (evidence-based policy at national and subnational levels including better data).

5 Selected academic institutes and civil society provide evidence and advocate for improved health services

Output 5: Universities, research institutes and civil society organisations are able to deliver evidence-based data, advocate for health financing and human resources for health with the central and local policy-makers, and provide technical assistance and training to districts and Puskesmas to increase health access for the poor and the near-poor.

This output will be delivered in the first instance by the ISP, whose first tasks will be to develop an implementation plan against these sub-outputs and manage the delivery of these activities. The feasibility of activities under this output that are transferred to management through the PMU will be assessed at the independent progress review in 2013–14.

Contributing activities

Sub-output 1: Establish a Health Policy Network that fosters excellence in improving access to primary care for poor people through:

- > increasing the capacity of selected academic institutes to conduct research about the health of poor people
- > making evidence and research available to policy-makers in an accessible format
- > developing and delivering training and assistance to provincial and district health staff.

Support to the network will include:

- > TA support for:
 - training on writing policy briefing and presenting evidence to policy-makers

- funding for research in key identified areas (for example, poverty and poor people), especially to link in with the planning for the next national health strategic plan.
- > competitive grants rounds to develop innovative research methodologies and stronger critical mass of research in the area of access to primary health care for poor people. This could include national and international collaboration
- > funding health policy think tanks, meetings and workshops, roundtables and policy meetings to disseminate results to bring evidence to policy—especially maternal and neonatal health
- > funding and TA for the Health Policy Network to develop stronger regional health policy research capacity in institutes that can support PHOs and DHOs in policy-making.

The ISP will be responsible for the development and establishment of the Health Policy Network, in close consultation with the PMU and the Technical Working Group. This will involve:

- > assessing institutions for the Health Policy Network
- > finalising the terms of reference and implementation mechanism
- > providing ongoing TA and support to the Health Policy Network
- > establishing a monitoring and reporting framework for the Health Policy Network
- > managing the implementation of the Health Policy Network.

Sub-output 2: Establish a Civil Society Challenge Fund that supports selected civil society groups, including professional and women’s organisations, to:

- > develop capacity to respond to and demand better pro-poor health policy
- > hold health offices and primary health care providers accountable for the services they provide
- > conduct research to inform health advocacy and policy.

The ISP will be responsible for the development and establishment of the Civil Society Challenge Fund in close consultation with the PMU and the Technical Working Group. Establishing the fund will involve:

- > agreeing the scope and terms of reference for the Civil Society Challenge Fund in close consultation with the PMU and the Technical Working Group
- > managing the development and implementation of the Civil Society Challenge Fund.
- > in the medium term, adapting the Civil Society Challenge Fund to support the establishment of a civil society network or umbrella organisation to help organise and coordinate civil society participation in health policy discussions.

Annex 7: Program governance, management and implementation arrangements

Introduction to the modality

The AIPHSS program will be partially harmonised with the Global Fund HSS grant. The AIPHSS program will share governance and implementation arrangements with the Global Fund, but will have separate management arrangements. This is because the two programs, while supporting health systems strengthening, were designed at different times, focus on different parts of the health system and therefore have different counterparts within the Ministry of Health (MoH). Therefore, the AIPHSS program will not report to the Global Fund Country Coordinating Mechanism, and is partially harmonised. This is so that the MoH can harness the program synergies and maximise outcomes. In addition, both donors can work together to provide consistency in approach and, by harmonising their differing requirements, minimise transaction costs for the Ministry of working with two donors.

The program will be implemented through an Implementing Service Provider (ISP) and a Program Management Unit (PMU). The PMU will sit within the MoH and administer AusAID ‘ringfenced’ grant funding, using the processes and procedures of the Global Fund grants for Indonesia.

There are a number of compelling reasons for this approach:

- > The desire to maximise Government of Indonesia ownership of this program led to the consideration of a modality that would put the Government ‘in the driver’s seat’.
- > There was a strong desire to harmonise and coordinate the approach of the Global Fund and AusAID to health systems strengthening in Indonesia. (The Global Fund is currently negotiating a five-year, US\$37 million health systems strengthening grant for Indonesia, focusing on pharmaceutical supply chain and information management.)
- > A joint approach is likely to provide greater leverage for AusAID funds.
- > Australia has a broader interest in the Global Fund as a significant donor and interest in encouraging the Global Fund to pursue health systems strengthening alongside its vertical programs.
- > AusAID as major donor in Indonesia and major donor to the Global Fund has a strategic interest in ensuring the success and coordination of health systems strengthening work in Indonesia.
- > There was a desire to maximise complementarities, efficiencies and synergies.
- > There was a desire to minimise transaction costs on the Ministry. (The Global Fund has successfully used Government of Indonesia systems to execute \$340 million of grants.)

However, a partially harmonised approach is not without risks. Although the reputation of the Global Fund in Indonesia is strong, there have been some concerns internationally about the Global Fund's approach. The key to minimising these risks is to harmonise with the Global Fund model where it is sensible and advantageous, and to have separate arrangements where it is more sensible to do so. A more detailed discussion is below.

This annex summarises the program governance, management and implementation arrangements that have been agreed between AusAID and the MoH. The contents of this annex are:

1. Rationale for the selection and design of the aid modality
2. Oversight arrangements that are clear, involve the Government of Indonesia and AusAID in joint accountability for strategic decisions on the performance and direction of the program
3. Management arrangements that emphasise national leadership and ownership and that delineate responsibilities clearly to ensure that there is full accountability and no confusion
4. Implementation arrangements and clear roles and responsibilities for all the key partners with a stake in program oversight or a role in program implementation
5. A summary of the strengths and weaknesses of the proposed approach.

1 Rationale for the selection and design of the aid modality

During the program design process, a number of options for aid modality and implementation mechanism were considered. The best-designed program:

- > is most likely to support achievement of program outcomes
- > is most likely to support national ownership and leadership
- > includes robust financial risk management to protect AusAID money from misuse or leakage
- > maximises policy dialogue between AusAID and the MoH
- > minimises transaction costs for AusAID and the MoH
- > is flexible to allow scale-up with additional resources in the future
- > may be extended beyond the first five years
- > can accommodate other potentially interested donors
- > is based on international best practice
- > can start quickly (in early 2012).

The other forms of aid considered included:

- > partnering with a development bank, in particular the World Bank, but also possibly the Asian Development Bank
- > partnering with a UN agency
- > seeking sector budget support
- > contracting a private sector managing contractor.

The modality proposed was assessed as the strongest against the criteria above. In particular, it is the only modality that could enable strong government ownership and

robust financial risk management. It positions AusAID very well for future additional financial support in a second phase after 2016 by:

- > enabling AusAID to develop credibility and a track record in supporting government to strengthen health systems
- > providing AusAID with a platform for a strong policy dialogue with government
- > enabling testing of use of national systems for AusAID funding in a relatively safe environment before considering greater scale-up of support.

The strongest alternative option would have been a World Bank Trust Fund. That alternative was discounted because of the low interest of the MoH in taking out additional World Bank loans for the health sector, and the risk of reducing national ownership and of limiting AusAID policy dialogue with the MoH. It would also have required a much longer design process. However, the program should keep open the option of linking with the World Bank on future analytical work as long as this work is conducted in a way that ensures government ownership of the results and findings. There are no UN agencies with a track record or expertise in strengthening health systems in Indonesia to consider for this type of program. The option of engaging a private sector managing contractor was also considered but it was determined that such an arrangement would be unlikely to achieve the high level of partner government ownership and leadership required. Sector budget support was discounted for two main reasons: first, it does not score well against the financial risk management criteria; and second, there is the risk that the level of AusAID funding, by being relatively low compared to government funding, would not leverage sufficient additional results and could suffer the same inefficiencies that affect disbursement and use of the government budget.

The design proposes partial harmonisation with the Global Fund HSS program (the details are outlined below under ‘Implementation arrangements’). The principal benefits of this approach are:

- > use of the existing and proven Global Fund aid management model, which is country led and has strong fiduciary risk management
- > potential synergies to the Government of Indonesia of bringing two health systems strengthening funding streams in alignment with national priorities
- > complementarity of AusAID support for human resources and health financing with Global Fund support for health information systems and pharmaceutical supply chain management
- > the potential for AusAID to influence implementation of Global Fund support and leverage greater outcomes. This is particularly important because of AusAID’s support to the Global Fund globally and in Indonesia through the Debt2Health program.

Despite the many advantages, there are a number of risks associated with the Global Fund mechanism. The key risks of this harmonisation are seen to be:

- > the Global Fund’s slow grant disbursement record, which limits the impact of its funding
- > global perceptions of misuse of Global Fund grants being applied to Indonesia (real or perceived)
- > increased transaction costs for AusAID staff for policy dialogue and managing key national-level relationships—aid coordination always takes more time than envisaged

- > the tendency of countries to develop parallel management, planning and reporting structures to implement Global Fund programs.

Internationally, concerns have been raised about aspects of the Global Fund operations, particularly the sustainability of the approach, which relies on salary supplementation and/or incentives to staff involved in the grant implementation; the role of the Local Funds Agent (LFA); the cost effectiveness of interventions; and the tendency of countries to develop parallel management, planning and reporting structures to implement Global Fund programs and meet Global Fund reporting requirements. Other concerns were raised in a review by the Global Fund's independent Office of the Inspector General, released in 2009,¹⁰² including the following:

- > Procurement and logistics management of pharmaceutical products were not executed in line with best practice and Global Fund guidelines.
- > The Office of the Inspector General audits showed that most principal recipients (PRs) audited had weak financial management and internal control, making Global Fund grants susceptible to fraud. These risk factors were either not identified by the PR assessments undertaken by LFAs or, if identified, had not been remedied at the time of the audit.
- > Monitoring and evaluation frameworks for Global Fund grants in several countries were not operating effectively.
- > The adequacy and quality of the work done by the LFAs had been affected by:
 - lack of the right skill mix to execute their roles
 - lack of effective execution of their role because many of the critical issues raised in the Office of the Inspector General country audits were obvious and should have been picked up by the LFAs as part of their assessment or verification of implementation
 - the terms of reference of the LFAs failed to respond to the specific risks associated with the Global Fund grants in different countries.

Since this report was issued, the Global Fund has responded to these findings in part by issuing upgraded guidance to LFAs on the assessment of country and PR risks.

We believe that some of these risks are not critical for the AIPHSS program for the following reasons:

- > The AIPHSS program will not be procuring pharmaceuticals.
- > AusAID has been advised by the Global Fund that the LFA in Indonesia (PricewaterhouseCoopers) is among the best LFAs in the Global Fund portfolio. It has not been subject to the same criticism as some of the other LFAs (particularly in smaller states and Africa) that the Office of the Inspector General report highlighted. Obviously, it is incumbent on AusAID staff to ensure that any recommendations that the LFA makes in the PR assessment will be acted on.
- > As far as AusAID is aware, monitoring and evaluation has not been a problem in Indonesia. Nonetheless, the AIPHSS program will invest more in monitoring and evaluation than the Global Fund does. AusAID will employ a full-time Monitoring

¹⁰² Office of the Inspector General: Report on Lessons Learnt from the Country Audits and Reviews Undertaken (3 September 2009)

and Evaluation Adviser for the AIPHSS program to strengthen and oversee the quality of the monitoring and evaluation frameworks.

- > This program uses the Global Fund modality for financial management and planning, but not for identifying interventions (or the most cost-effective interventions), for which the program will have strong technical input to annual planning and joint Government of Indonesia – AusAID oversight through the Program Steering Committee (PSC).

The Ministry of Health and AusAID want to ensure that the program does not result in unsustainable parallel management, planning and reporting structures and systems that increase transaction costs on country staff. At the national level, the PMU will be part of the Bureau of Planning and Budgeting. At the provincial and district levels, staff contracted to administer the AusAID program will be integrated within provincial health offices (PHOs) and district health offices (DHOs). The format, timing and process of developing work plans should be integrated with national planning processes, and the Global Fund HSS should be encouraged to integrate its processes with national ones, if this is not already the case. However, it is important to ensure that approval work plans and disbursement of funds to provinces and districts are not subject to the same delays as those experienced within the Indonesian system.

In addition, AusAID believes that using a ‘partial harmonisation’ approach further minimises the risks of aspects of the Global Fund model that are considered unnecessarily duplicative or unsuitable for an AusAID grant (such as the Country Coordinating Mechanism) while providing benefits from aspects that are well established (such as the implementation arrangements). In line with the Government of Indonesia’s commitment to bureaucratic reform, the MoH has undertaken a review of salary structures. It is expected that Global Fund incentive payments will be phased out within the Ministry once these new arrangements are in place, and this is supported by the Global Fund and AusAID. AusAID and the Global Fund will continue current incentives until a new MoH salary structure is introduced.

On balance, AusAID, the MoH and the Global Fund agreed that the partial harmonisation approach should bring benefits and can minimise risks.

Overview

The AIPHSS program will be delivered through two modalities: an ISP and the Global Fund HSS PMU in the Ministry of Health. There will be a shared governance structure for both the ISP and PMU and joint aspects of the management structure.

Figure A7.1: Governance, management and implementation arrangements

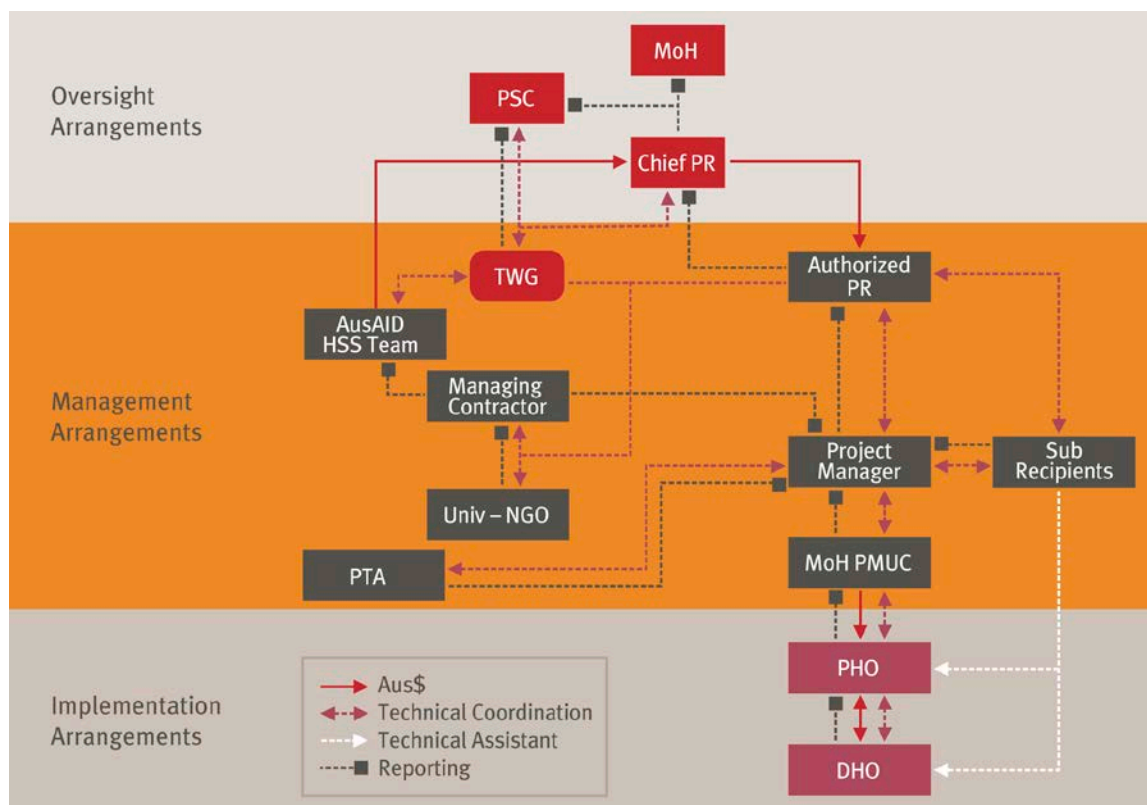


Figure A7.1 shows the results of negotiation between the MoH and AusAID. Consequently, the figure has some terminology that may differ from that used in the following annex, but the principles are largely the same. Details of roles and responsibilities of positions are set out in Attachment 1. It should be noted that there will not be separate provincial and district-level PMU structures because the responsibility for grant management will be within the PHOs and DHOs.

2 Oversight arrangements

The oversight and management arrangements have been designed to ensure joint accountability between the Government of Indonesia and AusAID, but also to ensure that it is clear where individual accountability and responsibility lies.

The two important aspects of the oversight arrangements to be shared between AusAID and the Global Fund HSS programs are the Chief Principal Recipient and Technical Working Group.

The Chief Principal Recipient is the person whom the Minister of Health authorises to manage—technically and administratively—both the AusAID and Global Fund HSS grants, and reports directly to the Minister of Health. The Chief Principal Recipient is the Secretary General of the MoH.

The second oversight mechanism is the joint AusAID – Global Fund HSS Technical Working Group (TWG). It may also be possible to integrate with the GAVI Alliance’s HSS funding technical working group. The TWG will ensure consistency between the AusAID and Global Fund HSS programs and ensure that the HSS grants are in line with the Ministry’s priorities and supporting their work. This group will comprise Echelon 2 and 3 staff from various directorates and bureaus across the Ministry, with a shared interest in health systems strengthening and primary health care. The HSS monitoring and evaluation expert will also be on the TWG. AusAID will be represented by the AusAID senior health policy analyst. The TWG will report to both the Global Fund oversight mechanism (the Country Coordinating Mechanism) and the AusAID oversight mechanism (the PSC).

The PSC has responsibility for setting the program’s strategic direction and monitoring progress. It should ensure that the program is contributing to improving the effectiveness of national programs so that poor people have improved access to quality primary health care services.

The PSC would comprise all the major national-level stakeholders under the leadership of the MoH, and representation from the provinces and districts (to facilitate national–district lesson learning and evidence exchange). Its key members would be: director-generals of the relevant MoH departments, Director General, International Cooperation, BAPPENAS, Ministry of Finance, Ministry of Home Affairs, AusAID and representation from some of the provinces and districts. The MoH will nominate its representative to chair the PSC. It is anticipated that the PSC will meet twice a year. It may be necessary to meet three or four times in the first year of the program to guide its inception and start-up. Thereafter, annual meetings to review progress and approve future plans, with mid-year monitoring, should be sufficient.

3 Management arrangements

AusAID has identified separate management arrangements from those of the Global Fund HSS grant. This is because the focus areas of the two HSS programs are different and, therefore, the location of the Principal Recipient and Program Manager should reflect the areas of focus. Accordingly, the AIPHSS program grant will be housed in the Bureau of Planning and Budgeting, whereas the Global Fund grant will be housed in the Data and Information Centre.

The Principal Recipient and the Program Manager will be different for the Global Fund HSS and AusAID AIPHSS grants. The reason for this is that although both the Global Fund and AusAID are working on health systems strengthening, they are focusing on different areas. The Global Fund proposal focuses on information management and pharmaceuticals, and is managed in the Centre for Data and Information Management (Pusdatin). The AIPHSS program design focuses on health workforce and health financing, and management of the program will be in the Bureau of Planning and Budgeting.

A Program Technical Specialist (PTS) will be employed by AusAID to support the Program Manager. Specifically, the PTS will support the Program Manager in evaluating plans of actions from subrecipients and advising on how likely the identified activities are to improve health systems, how well they are aligned with international best practice, and how well they support the Ministry’s objectives. The PTS will also oversee work plans

from the ISP to ensure consistency between all program activities. For detailed terms of reference for the PTS, see Attachment 4.

4 Implementation arrangements

The Global Fund has disbursed around \$340 million of grants in Indonesia since 2003, including \$300 million to the MoH. Their procedures for program and financial management are well established (see Attachment 5). There have been no problems with disbursements of funds since 2007.¹⁰³ The LFA provides important program and financial oversight. The LFA in Indonesia is PricewaterhouseCoopers, one of the best LFAs in the world, according to the Global Fund.

Having had years of experience following the Global Fund processes, MoH and subnational authorities are familiar with Global Fund procedures. In addition, the Global Fund does not seem to be plagued with some of the problems, such as delays in disbursement, that generally occur throughout the Indonesian system. Oversight mechanisms are rigorous and robust.

In order to generate efficiencies and synergies and minimise transaction costs on the Ministry, it has been agreed that both the Global Fund and AusAID HSS grants will follow the Global Fund's implementation procedures.

Program Management Unit

AusAID will establish a PMU in the Bureau of Planning and Budgeting. The management responsibilities of the AIPHSS PMU would include:

- > developing annual work plans and budgets
- > developing annual progress reports
- > accounting for all program funding utilised by MoH and provincial and district health management units
- > managing and ensuring good coordination and communication flows between PSC members and other national key stakeholders
- > convening and leading the TWG and day-to-day liaison with the managers of the Health Policy Network and the Health Resource Facility
- > putting in place a clear monitoring and evaluation plan and ensuring (with assistance of others) collection of relevant baseline data
- > contracting and commissioning universities and other national-level contractors to support implementation as required
- > preparing for PSC and TWG meetings.

For the detailed terms of reference, see Attachment 2.

AusAID will provide funds for staff in the PMU to manage the AIPHSS program funds. Staff within the PMU will adopt and follow the Global Fund processes for financial management, activity implementation, accounting, and auditing for the Global Fund and

¹⁰³ There was a problem in 2006 with a subrecipient, but this was resolved and there are now more stringent controls of subrecipients and tighter oversight by LFA.

AusAID grants. There will be very close cooperation between the PMU for AusAID and Global Fund HSS programs, potentially even co-location of offices.

The PMU would be led by a national program manager who reports to the Program Manager. It is anticipated that the PMU will also have a national program manager for Global Fund HSS funds and that the two managers and other PMU staff would coordinate and liaise to maximise complementarities between activities.

AusAID funds will be ringfenced from both Global Fund HSS funds and MoH funds. They will be held in a separate bank account. A more detailed outline of the funds flow and disbursement arrangements is at Attachment 3 (Figure A7.2).

AusAID will contract a PTS, who will work closely with the national Program Manager. Her/his role will be to provide high-level technical advice on health systems and health policy, and to assist the Program Manager in overall program coordination.

In line with the Government of Indonesia's commitment to bureaucratic reform, the MoH has undertaken a review of salary structures. It is expected that Global Fund incentive payments will be phased out within the Ministry once the new arrangements are in place; this is supported by the Global Fund and AusAID. The Global Fund currently provides salary for non-public service staff and incentives for ex officio staff to perform additional roles in managing or implementing Global Fund grants. Using the partial harmonisation approach with the Global Fund, AusAID plans to use the same pay scale and incentives, but will not duplicate any existing Global Fund incentive payments. This arrangement will end when the new MoH salary structure is introduced.

Because AusAID is proposing to use the Global Fund implementation arrangements, a number of important steps will need to be taken during the inception phase and which the PMU will need to do to disburse the grants. These include the following:

- > The PMU will develop a program implementation manual.¹⁰⁴ The manual provides clear and detailed guidelines for managing and implementing the Global Fund programs, including roles and responsibilities of all positions. It applies to the Principal Recipient, subrecipient, sub-subrecipient and implementing units under the coordinating of the Principal Recipient. The manual also includes salaries and incentives; procedures for establishing and clearing accounts; details outlining processes and procedures for procurement (including business trips, seminars and the funds disbursement mechanism).
- > The PMU will develop consolidated work plans and plans of action with subrecipients.
- > The PMU will provide detailed costing and activity plans, with a similar level of detail to that of the Global Fund round proposal. These will be integrated in format, process and timing with the national planning processes.
- > The PMU will develop a procurement plan (to be reviewed by the LFA).
- > The PMU will develop subgrant agreements for subrecipients (based on those of the Global Fund).
- > The PMU will develop agreements on performance of work (based on those of the Global Fund).

¹⁰⁴ The PIM for the Global Fund and AusAID HSS grants may be the same document. However, this will need to be confirmed with the Country Coordinating Mechanism.

- > AusAID will contract the LFA to provide financial and program oversight as outlined in Annex 5.

Implementing Service Provider

AusAID will contract an ISP to provide technical assistance, training and capacity building. The ISP will also be responsible for the establishment of the Health Policy Network and Civil Society Challenge Fund, developing specifications under the guidance of the Principal Recipient and Program Manager, with support from the PTS.

Other links with the Global Fund and the Country Coordination Mechanism

The Global Fund HSS program will have the usual Global Fund oversight and governance arrangements through the Country Coordination Mechanism; the AIPHSS program will not have those. However, it will be important for there to be some structured links between the two programs to:

- > enable additional benefits that may come from identifying potential synergies and joint planning, where appropriate, of complementary activities
- > ensure that strategic oversight of both programs contributes to strengthening Indonesia's health systems and domestic funding channels.

Specific links could include:

- > AusAID continuing its already active role on the Country Coordinating Mechanism
- > AusAID, Global Fund and MoH agreeing on basic principles and intentions for communication, information sharing and consultation in advance of important decisions being made, including potential for shared program evaluation and oversight missions
- > Global Fund PMU and AusAID PMU meeting monthly to coordinate work
- > PMUs aligning their planning cycles to seek potential synergies and jointly plan where appropriate.

Subnational level

The program will be delivered subnationally through PHOs and DHOs. Depending on the nature of the activity, technical assistance may be provided by the ISP or funds will be channelled from the MoH to the PHO and then to the DHO to implement previously agreed work plans.

The PHO and DHO that receive grants must follow procedures outlined in the manual and must also sign subgrant agreements for subrecipients. They will be subject to oversight and audit by the LFA.

5 Strengths and weaknesses of the proposed approach

Table A7.1 sets out some of the strengths and weaknesses associated with the proposed modality. Responses to weaknesses will be addressed in the risk management matrix.

Table A7.1: Strengths and weaknesses of the modality

Strengths	Weaknesses
<ul style="list-style-type: none"> > National ownership and leadership > National accountability for delivering outcomes > Encourages provincial and district control over planning and management of activities > Good opportunities for potential scale-up of AusAID support > Relatively low transaction costs for AusAID (3 contracts and program and fiduciary oversight by LFA) > Strong policy dialogue with MoH as AusAID dealing directly on funding > Strong on international best practice of aid effectiveness—scores well against OECD Paris Declaration indicators > Potential to strengthen health systems by operating from and improving systems from within > Partial harmonisation with another donor (Global Fund) > Potential to gain HSS synergies along with Global Fund HSS activities > Potential to influence and leverage value from Global Fund support 	<ul style="list-style-type: none"> > Potential fiduciary risk of financial management and accountability of government systems > May take time to set up national management systems (from MoH to provinces and districts) > If Global Fund grants are not well managed or open to suspicion of mismanagement, this could tarnish the reputation of the AIPHSS program > Risk of diluting policy dialogue if Global Fund presence and influence is greater

Attachment 1: Roles and responsibilities of various positions in the modality

Table A7.2 outlines the different positions that have a role in the AIPHSS program. Not all positions have management responsibilities.

Table A7.2: Roles and responsibilities in the modality

No.	Role	Person in charge	Task and/or responsible
1.	Authorised Person in Delegating Power	Minister of Health	Authorised to determine the usage of MoH goods and fund, as well as the usage of AusAID fund
2.	Program Steering Committee (PSC)	Echelon 1 + Head of Bureau of Planning and Budgeting + Head of Central for International Cooperation and Head of AusAID.	<ul style="list-style-type: none"> > Endorse annual workplans > Consider review report every six months > Agree evaluation report every six months > Give direction and input to the AIPHSS program implementation > Report directly to the Minister of Health
3.	Chief Principal Recipient (Chief PR)	Secretary General Note: Shared with Global Fund	<ul style="list-style-type: none"> > Responsible for technical and administration funds usage > Responsible for following up fund usage and program implementation then report to the Minister of Health and PSC > Responsible for monitoring subrecipients
4.	Technical Working Group (TWG)	Focal point from each subrecipient and AusAID Health Policy Adviser	<ul style="list-style-type: none"> > Provide technical inputs to PR and PSC in terms of program planning and implementation > Provide technical inputs to the proposed work plan from subrecipients and MoH/PMU > Assess annual workplans, evaluation and review reports and advise PSC.
5.	AusAID AIPHSS Team	AusAID AIPHSS team (see below)	<ul style="list-style-type: none"> > AusAID's role will include management of the program, including fulfilling its role in program governance, management and administration, and engagement with the MoH and key constituencies in policy discussions and continuous program improvement.

No.	Role	Person in charge	Task and/or responsible
6.	PTS (Program Technical Specialist)	Third party appointed by AusAID	<ul style="list-style-type: none"> > Provide technical inputs to ISP and PM on program planning and implementation > Coordinate with the AusAID AIPHSS team > Report to PM
7.	Implementing Service Provider (ISP)	Third party appointed by AusAID	<ul style="list-style-type: none"> > Coordinate with PM > Facilitate technical units' needs for the program implementation, in terms of technical assistance, training, and capacity building > Coordinate with the university and NGO, approved by the PR, for program implementation technical assistance > Coordinate technically with the PTS > Report to the AusAID AIPHSS team and PM
8.	Principal Recipient (PR)	Echelon 2 (appointed by Chief PR)	<ul style="list-style-type: none"> > Manage AusAID fund channelling through the PM > Report to Chief PR > Authorize subrecipients fund usage > Coordinate with AusAID via TWG
9.	Program Manager (PM)	Echelon 3 (appointed by Chief PR)	<ul style="list-style-type: none"> > Report to Chief PR via PR > Take part as the officer accountable for the commitment > Development of annual workplans and reports for TWG and PSC. > Review the proposed programs from subrecipients and MoH PMU > Arrange the fund channelling to subrecipients and MoH PMU
10.	Subrecipients	MoH Technical Unit	<ul style="list-style-type: none"> > Plan the AIPHSS program > Report to PM > Coordinate technically with PM and PR > Give technical assistance to PHO and DHO > Responsible administratively and financially to PM and PR

No.	Role	Person in charge	Task and/or responsible
11.	MoH Program Management Unit Coordinator	Bureau of Planning and Budget staff/civil servant retiree, working full time, appointed by Chief PR	<ul style="list-style-type: none"> > Organise AusAID fund > Report to PR via PM > Assisted by related units such as human resource, logistic, finance, and monitoring and evaluation
12.	Provincial Health Office (PHO)	Staff/civil servant retiree, working full time, appointed by Chief PR Note: Provincial PMU shared with Global Fund HSS	<ul style="list-style-type: none"> > Perform provincial program planning > Monitor program implementation at province > Report to MoH PMU; assisted by 2–3 staff to perform tasks related to human resources, logistics, finance and planning
13.	District Health Office (DHO)	Staff/civil servant retiree, working full/part-time, appointed by Chief PR Note: DHO PMU unlikely as staff will be integrated across DHO. Will consider sharing staff with Global Fund HSS where operating in same district	<ul style="list-style-type: none"> > Perform district program planning > Report to PHO; assisted by 2–3 staff to perform tasks related to human resources, logistics, finance and planning

The program will be managed within the Health Unit in AusAID Jakarta. Because of the intersection with the current investment in maternal and neonatal health and the need to transition some maternal and neonatal health activities to health systems strengthening in NTT, some AIPHSS staff will work across both programs.

The general division of work is as follows:

Unit Manager—Is responsible for managing the health unit, maintaining policy dialogue with the Government of Indonesia and other development partners, and ensuring the quality of deliverables from both the unit and the AIPHSS program. Manages the transition of program elements of the NTT maternal and neonatal health program into the AIPHSS program. Coordinates directly with the AIPHSS Program Manager in the Ministry of Health.

Senior Policy Analyst—Working with the Senior Health Analyst, is responsible for conducting or commissioning analytical pieces to inform future programming options. Will liaise with and advise other AusAID sector programs that are addressing health issues. Is responsible for promoting the program with Government of Indonesia counterparts, including outside the health sector.

Senior Program Manager—Is responsible for ensuring that the program implementation is progressing in line with plans and budgets. Synthesises the program’s monitoring and evaluation reports and uses those pieces of analysis to provide policy options that inform

the program's strategic direction. Coordinates closely with the program's Monitoring and Evaluation Adviser and the NTT maternal and neonatal health program. Supports AusAID representatives on the Technical Working Group and Program Steering Committee.

Program Manager—Is responsible for contractual oversight of the program to ensure successful delivery; this includes commissioning reviews of program implementation. The Program Manager will coordinate closely with the Program Management Unit and the ISP.

Program Officer—Is responsible for overall program support to the unit, including compliance with AusAID corporate requirements.

Senior Health Analyst—Represents AusAID on the Technical Working Group and provides technical support to the AusAID team. Provides strategic input into the program and engages with the Ministry of Health and other constituencies to identify opportunities for the program to assist with systems reform. Ensures links with other AusAID programs to advance the objectives of the AIPHSS program.

Director, Health, AusAID —Is responsible for strategic oversight of program and management consistent with the overall health policy agenda for AusAID in Indonesia. Represents the program and its future direction, including more broadly across the AusAID program.

In addition to the above personnel, the program will also require the part-time inputs of Canberra-based health advisers and a health sector analyst from the Indonesia Desk. The health sector analyst will be responsible for documenting program lessons in a format accessible to other country programs, ensuring that the program is up to date with AusAID's broader strategic policies, and liaising with Australian stakeholders.

Attachment 2: Terms of reference for the Program Management Unit Coordinator

The PMU is the unit under the Program Manager or Principal Recipient who is responsible for managing finance, monitoring and evaluation, human resources development, procurement and supply, and administration of the program. The PMU is led by the PMU Coordinator, who has the following tasks and responsibilities:

- > coordinate the work of the program management units, namely human resources development, finance, logistics (including procurement and supply management), and planning, monitoring and evaluation.
- > lead and facilitate the development of work plans and plans of action by the Principal Recipient and subrecipients
- > be responsible for the general and financial administration of the program, including the verification of expenditures and financial reports
- > lead the analysis and assessment of financial and program performance based on monthly reports and quarterly achievement indicators and disseminate the results to each unit for follow-up and proposed action to be taken to the Program Manager
- > co-authorise payments at the Principal Recipient level in conjunction with the Program Manager and the Principal Recipient. All payments must be authorised by two of three authorised individuals: the Principal Recipient, the Program Manager and the PMU Coordinator
- > co-sign cheques with the Principal Recipient and/or the Program Manager for cash withdrawals for program funded by AusAID expenditure
- > authorise finance staff to transfer funds to subrecipients
- > be responsible for timely, accurate and safe disbursement of funds to subrecipients
- > provide guidance for subrecipients on activity implementation and monitor their compliance with the terms of the subgrant agreement and Global Fund requirements
- > be responsible for the implementation of the Principal Recipient's audit of the financial performance of subrecipients and monitoring of subrecipients' internal audits as required
- > lead logistics planning relating to program funding by AusAID
- > develop subgrant agreements for subrecipients based on Global Fund requirements
- > develop agreements on performance of work and other documents required in relation to Global Fund funding.
- > be responsible for the availability and integrity of all program documentation, including supporting documents for the use of funds
- > maintain and store all financial documents for at least five years, based on the grant agreement
- > work closely with subrecipients, the Program Manager and the Principal Recipient to take early action on issues arising in management and implementation, based on the findings of the internal or external audits, the Local Funds Agent, and the PMU's own monitoring

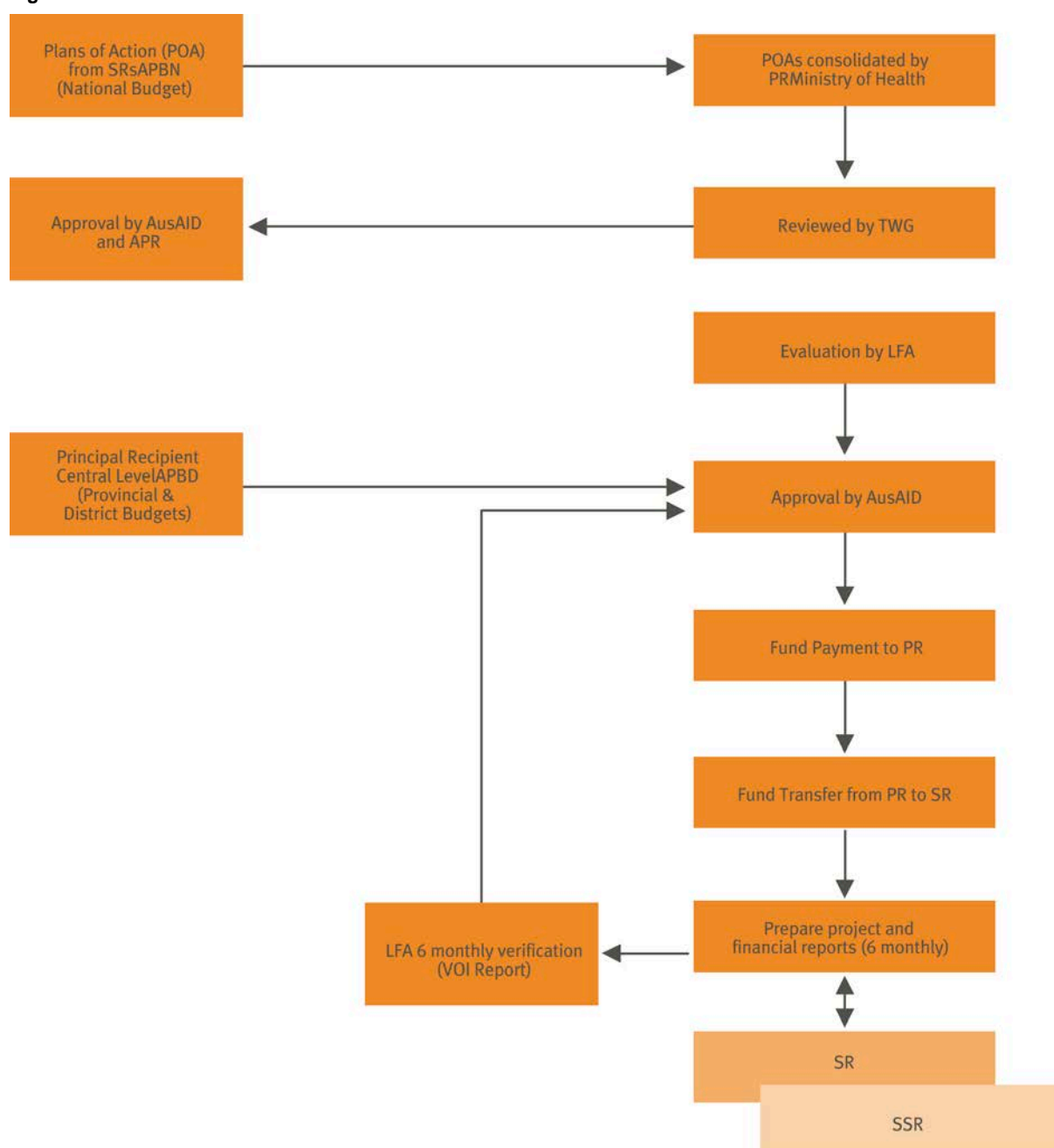
- > protect against conflicts of interest by following the procedures articulated in the program implementation manual, within the scope of his/her responsibilities.

Attachment 3: Funds disbursement mechanism

AusAID will provide a direct cash grant to the Ministry of Health to implement the program, based on the process outlined in Figure A7.2. Once plans of action have been received from subrecipients, consolidated, reviewed and approved, AusAID will transfer payment (on a biannual basis) to the Ministry of Health. The funds will be held in a special account within the Ministry, which must be registered with the Ministry of Finance.

The Ministry of Health transfers funds to subrecipients. Those funds must be accounted for six-monthly and be verified by the Local Funds Agent, before AusAID transfers the next tranche.

Figure A7.2: Funds disbursement mechanism



Attachment 4: Summary description of Global Fund Mechanism

The Global Fund's structures and actors

(Extract from *Operational Guide: The Key to Global Fund Policies and Processes*, which can be found at www.theglobalfund.org)

The Global Fund is made up of several interconnected structures that have different but reinforcing functions to make operations possible. Governing the Global Fund is the **Board**, which is responsible for determining policies, objectives and strategies of the Global Fund.

The **Technical Review Panel** is an independent, impartial team of disease-specific and cross-cutting health and development experts, appointed by the Global Fund Board to guarantee the integrity and consistency of an open and transparent proposal review process. At the operational level, the Global Fund **Secretariat** is responsible for the day-to-day business of the Global Fund.

Grants are implemented at country level by **Principal Recipients**, who are accountable for the achievement of results and for implementing a grant in a transparent and financially responsible manner. A Principal Recipient is legally responsible for the grant agreement signed between its representative and a Global Fund representative, and may under certain conditions contract subrecipients to implement certain program activities, who may in turn contract sub-subrecipients.

The Principal Recipient works under the oversight of the **Country Coordinating Mechanism** is a partnership of country stakeholders from government and non-government sectors. It is responsible for developing proposals to request funding from the Global Fund. It nominates the Principal Recipients who will implement the program, and oversees their performance during implementation.

Local Fund Agents, acting on behalf of the Global Fund, oversee, verify and report on the performance of grants and financial accountability at the country level. The Local Fund Agent does not make decisions on behalf of the Global Fund, but makes verifications and recommends remedial actions to the Global Fund.

Annex 8: Budget outline

Introduction

This annex summarises the outline budget for the AIPHSS program. This budget is not binding. The first task of the appointed national Program Manager will be to develop a full first-year budget using this framework but based on more comprehensive costing of activities with the Ministry of Health, provinces, districts and Puskesmas.

The budget draws heavily on the experience of the AusAID Indonesia–Partnership on Maternal and Neonatal Health (AIPMNH). It is built using a set of basic principles and assumptions.

1 Basic principles

The key principles for the budget are:

- > Activities at the provincial, district and Puskesmas levels should constitute a minimum of 60 per cent of the total budget because these are the activities most critical to achieving the program outcome.
- > Monitoring and evaluation should be approximately 6 per cent of the total budget.
- > Program management costs should be less than 5 per cent of the subtotal of the total activities budget to be consistent with the Global Fund.

2 Key budget headlines

The outline budget is in Table A8.1. The total estimated budget is \$49 415 000. Of this, 61 per cent (\$29.9 million) would be for provincial, district and health facilities to support systems strengthening and service delivery. A further 9 per cent (\$4.3 million) would be for Ministry of Health policy work, systems strengthening and research, and 4 per cent (\$2 million) would be for upgrading the Poltekkes.

Nine per cent (\$4.3 million) would be for technical assistance and operating costs for an Implementing Service Provider (ISP) and a further 4 per cent (\$2.1 million) would be for Health Policy Network and civil society work, which would be managed by the ISP, at least for first three years. Six per cent (\$2.8 million) would be for monitoring and evaluation (of which approximately \$1 million would be for a Monitoring and Evaluation Adviser to be managed by ISP).

It is anticipated that 4 per cent (\$2.06 million) would be for national, provincial and district program management, and that 10 to 12 per cent of the ISP costs would be administrative overhead.

The expenditure profile would start relatively low in the first year and peak in 2014–15. It is expected that \$40.05 million would be managed through the national Program Management Unit, and up to \$7.4 million through the ISP, and the remainder would cover the costs of the Program Technical Specialist and the Local Funds Agent. The budget for the Local Funds Agent, 1 per cent of the total, covers financial management oversight, performance oversight, audits and so forth.

3 Budget assumptions

The key assumptions behind this budget are:

- > Expenditure in 2010–11 will be relatively low because of start-up time and work load.
- > Expenditure in 2015–16 in provinces and districts is budgeted at 80 per cent of the previous fiscal year's budget. This is because programs do not stop on the final end date but wind down activities throughout their final six months.
- > Expenditure on other line items for 2015–16 is also expected to be lower than that of the previous fiscal year.
- > The Output 2 and Output 3 budget line includes all activities at the provincial, district and health facility levels. Cost estimates for Output 2 and 3 have been combined into one line because it will be difficult to separate costs for Puskesmas (Output 3) that will not have district level involvement, and vice versa.
- > The average unit cost for provincial and district activities draws on AIPMNH experience and is based on the following:
 - province allocation: \$600 000 for the first year of activities and \$900 000 for subsequent years
 - district allocation: \$100 000 for the first year of activities and \$300 000 for subsequent years
 - 2011–12—flat overall rate during set-up, of \$1 million for provinces and districts
 - 2012–13—two provinces and eight districts (plus additional \$1 million for preparing for the second phase of provinces and districts to start)
 - 2013–14 through to program end—five provinces and 20 districts.
- > Provincial and district costs cover training, technical assistance, activities, studies and technical advisory costs to support implementation of activities. This could include technical district coordinator roles if necessary.
- > It is expected that Output 5 will be managed by the ISP at least for the first three years of the program.
- > Output 1 costs include resources for the Ministry of Health to contract technical assistance, to fund studies and research, and to develop new systems as per agreed activity list and work plan.
- > Management (including national, provincial and district) costs include the costs of the PMU in the Ministry of Health, other salary incentives and management and administrative costs in the provinces and districts.
- > Monitoring and evaluation costs could include both funding through the Program Management Unit and technical assistance from the ISP.

- > ISP technical assistance and management costs include the ISP's core management costs and technical assistance to support all program activities. It does not include costs for Output 5.
- > No contingency has been built in. A contingency should be included.

Partnership for Health Systems Strengthening program indicative budget, 2011–12 to 2015–16, in Table A8.1: Australia–Indonesia \$'000

	2011–12	2012–13	2013–14	2014–15	2015–16	Total	%
Output 1	500	1,000	1,000	1,000	800	4,300	9
Outputs 2 and 3	500	3,000	8,000	10,000	8,400	29,900	61
Output 4	100	500	500	500	400	2,000	4
Output 5	200	500	500	500	400	2,100	4
Monitoring and evaluation	500	500	600	600	600	2,800	6
Subtotal: outputs and monitoring and evaluation	1,800	5,500	10,600	12,600	10,600	41,100	84
Management (national, provincial, district)	90	275	530	630	530	2,055	4
ISP technical assistance and management	500	1,000	1,000	1,000	800	4,300	9
Program Technical Specialist	300	300	300	300	300	1,500	3
Local Funds Agent costs	100	80	80	100	100	460	1
Subtotal: technical assistance and management	990	1,655	1,910	2,030	1,730	8,315	17
Totals	2,790	7,155	12,510	14,630	12,330	49,415	100
	6%	14%	25%	30%	25%	100%	

Note: Percentages do not necessarily add up to 100 because of rounding on each budget line.

Annex 9: Theory of change and monitoring and evaluation

Introduction

This annex summarises the theory of change and the monitoring and evaluation framework for the AIPHSS program. It includes:

1. Problem analysis—why do poor people suffer poor health in Indonesia?
2. Theory of change
3. Monitoring and evaluation framework: the logical framework
4. Key points for program inception: monitoring and evaluation

A point on terminology in this and other program documents and annexes for the AIPHSS program:

impact = goal

outcome = purpose

output = end-of-program outcome

The outputs are the statements that define a visible change at the end of the program. The outputs contribute to achieving the next level of change: the outcome. The goal is the longer-term vision. It links to the Millennium Development Goals and will be measurable after the life of the program.

1 Problem analysis—why do poor people suffer poor health in Indonesia?

Multiple factors explain why poor and near-poor people are not benefiting from good health in Indonesia (see Annexes 1 and 2, which analyse the available Indonesian data). The high-level factors include the low levels of health care utilisation (particularly primary health care), which is the factor that this program intends to address. Other factors that negatively affect the health of poor people include poor access to safe water and sanitation; low employment and income; limited nutrition and diet; low levels of education, in particular, female education; and lack of access to broader social assistance.

Analysis of health service utilisation in Indonesia (outlined in more detail in Annexes 1 and 2) suggests that there are a number of factors that contribute to poor people not using and benefitting from quality primary health care in Indonesia. These include:

- > lack of health workers in primary health care facilities
- > cost of health care that discourages its use by the poor and near-poor
- > low quality of the health workforce
- > low quality of health care

- > perceptions of low quality of health care
- > geographical inaccessibility of health care facilities
- > lack of consistent availability of affordable quality drugs and medicines
- > weak health information systems
- > policies that are not sufficiently pro-poor
- > incomplete policy implementation.

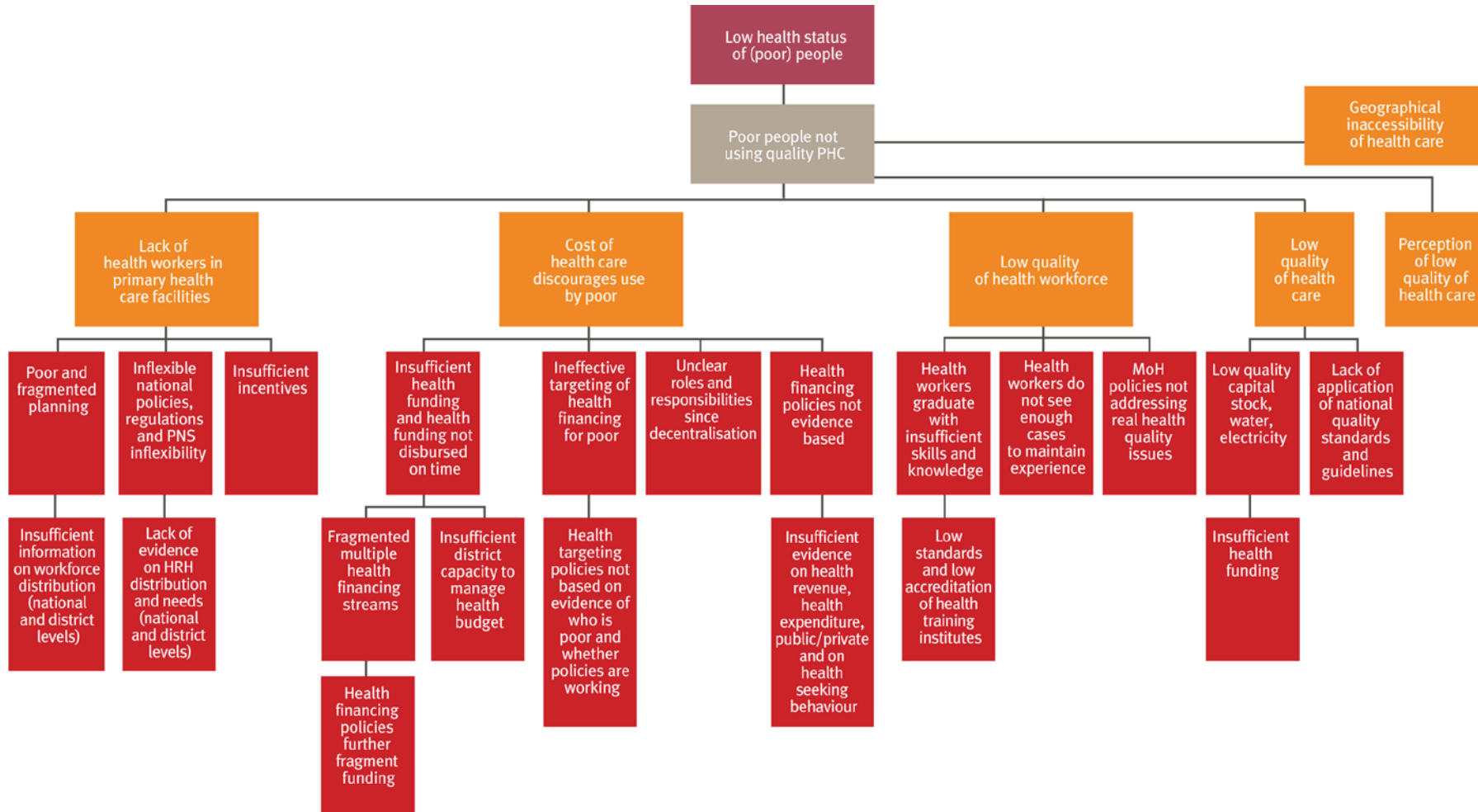
The problem analyses presented in Figure A9.1 focus mostly on the health workforce, health financing, and the insufficient capacity for decentralised planning, budgeting and supervision. Considerable analysis and evidence suggests that these are critical obstacles to improving the quality of primary health care. Annex 1 summarises the research on this, drawing on Government of Indonesia and World Bank data and research. Health financing and workforce are critical inputs to high-performing health systems, alongside a sound infrastructure and availability of equipment and medicines. This program has been designed to address health financing and health workforce because these are critical gaps. It focuses explicitly on publically, not privately, funded health care because this is over 50 per cent of total health expenditure, is increasing and offers the opportunity for AusAID funding to influence and improve the efficiency and effectiveness of government health funding. This is important for a middle-income country where donor funding is relatively marginal to total health expenditure. The Government of Indonesia is receiving support from the Global Fund to focus on pharmaceuticals and health information systems. GAVI Alliance funding for HSS granted in 2008 is currently being reprogrammed. Other development partners, including the World Bank, the Asian Development Bank and WHO, support the Government of Indonesia, particularly in the area of evidence for policy development.

This program has been designed to address some but not all of the above factors, primarily the first five and the final two. Figure A9.1 presents a more detailed problem analysis of the key problems that contribute to poor people not accessing sufficient quality primary health care. Figure A9.2 presents a more detailed problem analysis of the key problems that contribute to health policies not sufficiently addressing the needs of poor people, which underlies the factors contributing to poor people not using and benefiting from primary health care.

The program focus on the supply of health services has been chosen because, in the Indonesian context, demand is being stimulated through cash transfer programs and social health insurance, but health services lag behind in meeting demand. The importance of civil society in generating demand for evidence-based health policy to improve access for the poor is recognised in the program. It is anticipated that improving the quality of primary health care and removing the financial barriers to that health care will in turn begin to stimulate increased demand—in particular in poorer remote and rural areas. There is ample evidence globally that reducing financial barriers to health care itself is a big stimulus to increasing utilisation.¹⁰⁵

¹⁰⁵ World Health Organisation, The world health report 2010: health systems financing: the path to universal coverage. Geneva 2010.

Figure A9.1: Low health status of the poorest in Indonesia—problem identification and analysis



The boxes indicated in red are those that are the primary focus of the AIPHSS program.

Figure A9.2: Pro-poor health policy—problem identification and analysis

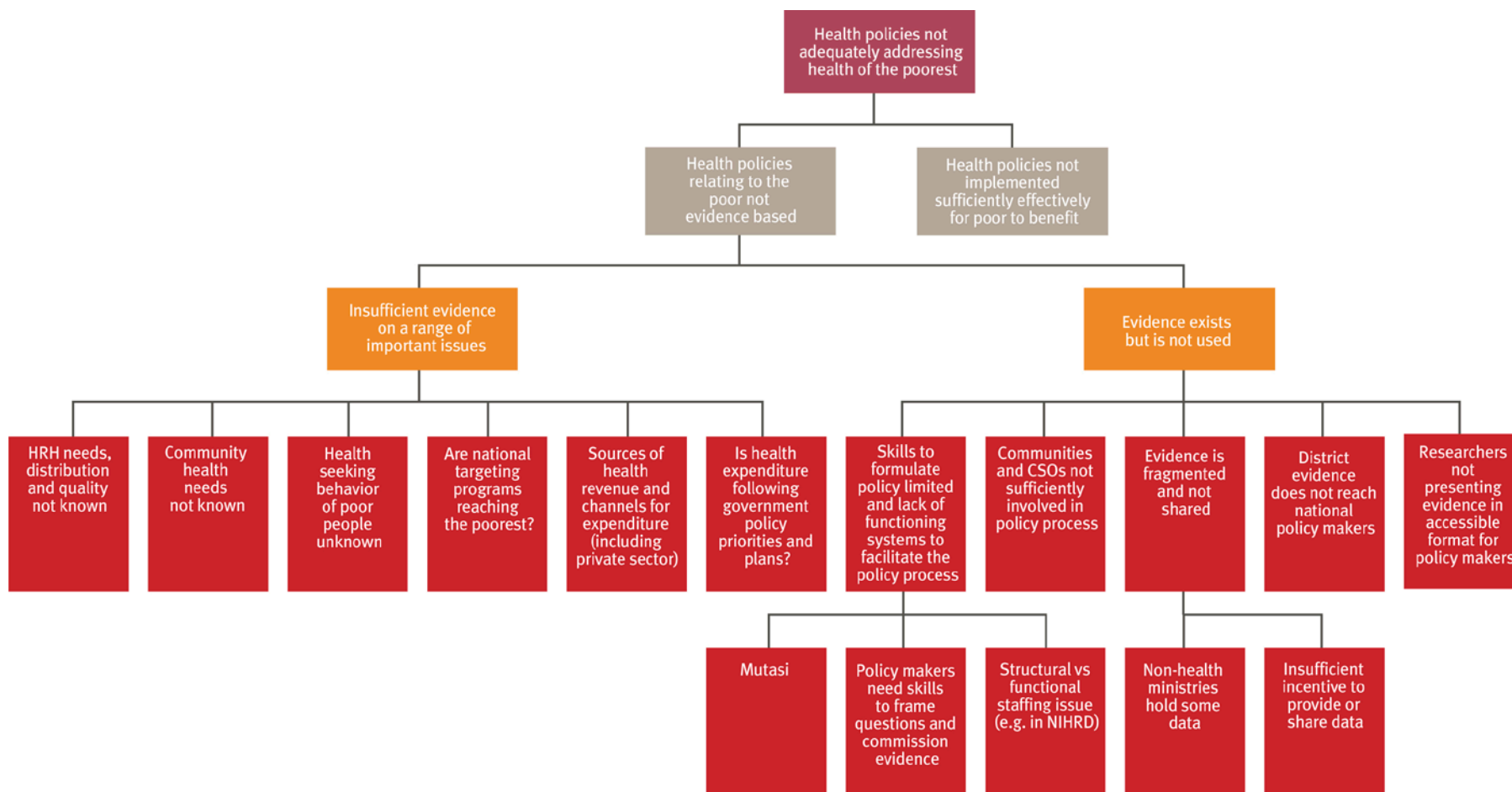
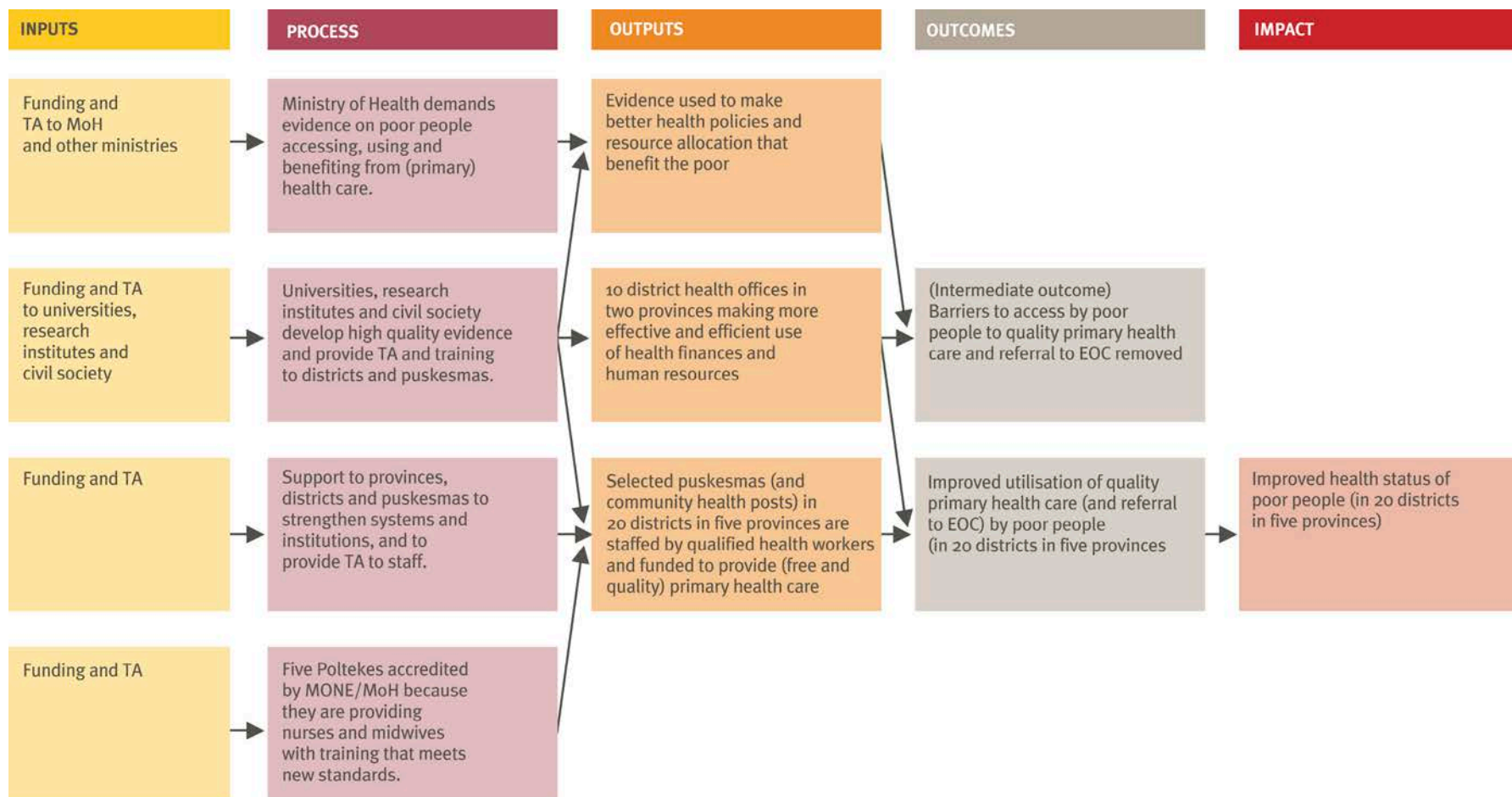


Figure A9.3: Theory of change—Australia–Indonesia Partnership for Health Systems Strengthening



Note: The terminology to describe some process, outputs and outcomes is a shortened version of the full logframe to enable ease of viewing on one page.

Source: Based on the WHO framework for monitoring and evaluating health systems strengthening (http://www.who.int/healthinfo/HSS_MandE_framework_Nov_2009.pdf).

2 Theory of change

The theory of change is outlined in Figure A9.3. The theory draws on the WHO Framework for Monitoring and Evaluation Health Systems Strengthening to structure the relationship between inputs, processes, outputs, outcomes and impact. Outputs in this framework are configured a little differently to outputs in the program's logical framework because the logical framework goes beyond the theory of change and separates out some processes as outputs for ease of explaining the main elements of the program. The elements that are treated as outputs in the logical framework are the research and technical assistance function of universities and civil society, and the accreditation of nursing and midwifery polytechnics (Poltekkes).

Key assumptions for planned inputs and processes to achieve change at the output level

Program activities have been developed using the experience of the Australia–Indonesia Partnership for Maternal and Neonatal Health (AIPMNH), a workshop with Ministry of Health officials and the international experience of comparable health systems strengthening programs. Program activities are outlined in more detail in Annex 6. They are based on the problem tree analysis and identification of activities required to address the issues identified, and they contribute to the stated outputs.

Output 1

Achievement of Output 1 requires the Ministry of Health to build stronger capacity to:

- > identify data needs
- > commission research to provide needed data
- > build analytical skills to use data in development of new policies
- > effectively disseminate results so that evidence is taken up in policy.

The proposed indicators measure the outcome that would be expected if the relevant Ministry of Health departments have built capacity. The inputs and activities that will be required include technical assistance to identify and commission data, financial support to carry out research and generate data, and technical assistance to analyse and incorporate data in policy development. The overall approach to technical assistance will be to focus on building the capacity of institutions and systems. Depending on the specific issues to be addressed, it could also involve the provision of ongoing mentoring and coaching.

Output 2

Achievement of Output 2 requires provincial and district health offices to build stronger capacity to:

- > plan for more effective use of financial and human resources to deliver primary health care
- > develop and monitor results frameworks that capture benefit to the poor and near-poor
- > provide leadership and supervision.

The proposed indicators measure the outcome that would be expected if provincial and district health authorities have developed these capacities. The inputs and activities that will be required include technical assistance to support needs assessments for capacity development for planning and budgeting, assessments of district population health needs, technical assistance and training for provincial and district health officials and financial support to training, surveys and needs assessments.

Output 3

Achievement of Output 3 requires Puskesmas management and administrative staff to develop stronger capacity to plan and use human and financial resources to deliver key services to poor people. The proposed indicators measure the outcome that would be expected if Puskesmas have built capacity and are delivering services to the population. The inputs and activities that will be required include technical assistance for staff in planning, budgeting, monitoring progress, needs assessment of the people, monitoring the use of services by the poor, development of appropriate operating procedures and quality assurance processes, and financial support to implement activities and training for staff to improve to service delivery.

Output 4

Achievement of Output 4 requires nursing and midwifery polytechnics (Poltekkes) to have developed increased capacity to deliver quality training programs that meet new, higher government-level accreditation standards. The proposed indicators measure the outcome that would be expected if Poltekkes have developed capacity and met new accreditation standards. The inputs and activities that will be required include technical assistance to the Ministry of Health to upgrade curriculum and teaching methods and to support Poltekkes to assess their needs and build capacity; technical assistance to Poltekkes to build capacity; and financial support for facility upgrades, activities and training to improve performance to deliver standards.

Output 5

Achievement of Output 5 requires universities and research institutes to develop capacity to:

- > conduct research on the health of poor people
- > make evidence and research accessible to health policy-makers
- > develop and deliver training courses and assistance to provincial, district and Puskesmas staff.

It also requires civil society organisations to develop capacity to generate and use data and evidence to advocate for improved primary health care for poor people, and to work with communities to generate demand for primary health care. The proposed indicators measure the outcome that would be expected if research institutes, universities and civil society organisations have developed those capacities. The inputs and activities that will be required include technical assistance to researchers on innovative research methodologies for understanding the needs or benefits of poor and near-poor; competitive research grants technical assistance to make research more accessible to policy-makers; and technical assistance on how to deliver quality training programs to

provincial, district and Puskesmas staff using modern adult learning techniques. Financial support will be included for these activities, and for civil society to:

- > generate demand for evidence-based policies and services
- > play a role in advocacy and accountability for expenditure at primary health care facilities
- > conduct research for health advocacy.

There are a number of key assumptions behind the translation of inputs into outputs:

- > Key staff in management, finance and procurement roles stay in post long enough to see through changes and sustain increased capacity, and measures are put in place to mitigate the effects staff rotations that will inevitably occur.
- > Systems to mitigate the turnover of staff in district health offices and provincial health offices (and Puskesmas) are set up and functioning.
- > Districts develop the management capacity and incentives to deliver services consistent with MoH and AIPHSS program priorities.
- > Quality of health services—including skills and motivation of staff and availability of the right medicines, supplies and equipment—is sustained.

Key assumptions for planned outputs to achieve change at outcome and impact level

The program is designed on the basis of a problem analysis that suggests that improving health outcomes of poor people requires activities and capacity development at the implementation level of Puskesmas, the management and supervision levels of districts and provinces, and the policy and stewardship level of national government. The outputs have been developed accordingly.

The outputs have been weighted according to their proportionate contribution to achieving the overall outcome. The output weighting—the percentage of total contribution of all outputs to achieve the outcome—of Outputs 2 and 3 is collectively estimated at 70 per cent; of Output 1, 15 per cent; of Outputs 4 and 5, 7.5 per cent.

There are a number of key assumptions behind the translation of outputs into outcome and impact:

- > The Government of Indonesia continues to increase funding for health care, in particular for the poor (Jamkesmas), for maternal and neonatal health (Jampersal) and for service delivery (BOK).
- > Improvement in quality and accessibility of primary health care services is recognised by poor people, reducing barriers and increasing demand.
- > Improvements to systems and process in district health offices lead to improved resource allocation, and more effective and timely disbursement of health resources.
- > Other programs on decentralisation result in the planning, budgeting, approval and disbursement cycle working more quickly to enable the disbursement of health funds from the national level to begin in the first quarter of each year.
- > Support to civil society can increase the demand of poor people for health care by increasing awareness of their entitlements from government funding schemes.

- > Technical assistance, reforms to systems and oversight are sufficient to ensure that health funding is used for the intended purposes.
- > The Government of Indonesia continues to implement other measures to improve health, including improved nutrition, education (particularly of girls), clean water and sanitation

3 Monitoring and evaluation framework: the logical framework

This framework outlines the high-level elements in the logical framework. Activity-related targets, including systems development and capacity development, will be developed alongside annual work plans in the inception phase.

Program name	Australia–Indonesia Partnership for Health Systems Strengthening	Data source	Comments
Impact (beyond scope of program)	Impact Indicator 1		
Improved health status of poor people.	1. Maternal mortality rate decreased from 228 per 100 000 live births (2007) to 102 (2014 target)	Indonesia Demographic and Health Survey	National data will not measure program. Survey conducted approximately every three years but reliant on donor funding.
	Impact Indicator 2		
	1. Under-five mortality decreased from 44 per 1000 live births (2007) to 32 (2014 target).	Indonesia Demographic and Health Survey	National data will not measure program. Survey conducted approximately every three years.
Outcome (by completion of program)	Outcome Indicator 1		
Improved utilisation of quality primary health care and appropriate referral by the poor and near poor to achieve the health MDGs (in 20 districts in 5 provinces).	1. X% increase in proportion of deliveries in facilities in lowest 40% socioeconomic status	Data could be collected and reported in the National Socioeconomic Survey (Susenas) with potential for oversampling in program targeted areas.	Standard global skilled birth attendance modified for Indonesia because of national policy focused on facility based delivery
	Outcome Indicator 2		
	1. X% increase in the number of women and neonates with complications who are referred for, and receive appropriate management (in lowest 40% socioeconomic status).	Administered data sets with Susenas providing socioeconomic status data.	AIPMNH modified
Outcome Indicator 3			
	1. X% increase in completion of ante natal and post natal care among lowest 40% socioeconomic status; or gap in coverage of ANC and	Data already reported nationally? May not be disaggregated by quintile and need to use Susenas or other	Standard global indicators modified as per AIPMNH

Program name	Australia–Indonesia Partnership for Health Systems Strengthening	Data source	Comments
	PNC between rich and poor districts reduced. ¹⁰⁶	survey.	
	Outcome Indicator 4		
	1. Number of primary health care visits per 10,000 people per year (lowest 40% socioeconomic status) in 20 districts in five provinces.	Routine health facility reporting system; maybe need Susenas or other population based survey.	Adapted from WHO Health Systems indicators. Need disaggregation by quintile to check poor and near-poor are benefiting.
Output 1	Output Indicator 1.1		
The Ministry of Health uses evidence-based data and up-to-date information to make national-level policy' decisions on health financing and health human resources to improve access to and the quality of primary health care for the poor and the near-poor.	1. X% increase in the number of demands from MoH (and other ministries) for poverty-relevant studies, data and information	Program records. Qualitative analysis.	Indicator is to measure demand for evidence. An output indicator in its own right, but also proxy indicator for capacity of MoH to identify evidence they need for policy.
	Output Indicator 1.2		
	1. 2015 national health strategy linked to national needs and priorities, which includes explicit measures to improve the health of the poor and near-poor.		Modified from standard WHO Health Systems indicator to include focus on poor and near-poor.
	2. Program-generated evidence and data referenced in policy briefs, documents and national strategic plans.	Program records.	Optional indicator to track program activities through to policy level.
	Output Indicator 1.3		
	1. Improved human resources for health information system providing data to support national, provincial and district management.	MoH and program records on sources and use of data on human resources for health.	
Output 2	Output Indicator 2.1		
Health offices in 20 districts in five provinces implement health financing and human health resources policies and programs more effectively and efficiently to improve access to and the quality of primary health care for the poor and the near-poor.	1. 20 district/city health offices making and reporting on annual health plans with a performance framework which includes measures to improve health of the poor and near-poor.	Plans exist—need qualitative review of incorporation of performance framework with focus on the poor and near-poor.	Indicator to track overall role of district to plan and manage health care. Proxy for capacity of district office.
	Output Indicator 2.2		
	1. Monthly budget utilisation rate of 20 districts increases for all national, provincial and district funding sources for primary health care (e.g. BOK, Jampersal, etc.).	Routine provincial/district health office budget and expenditure data from national, provincial and district levels. Possibly supplemented by	Indicator to track whether health expenditure is improving, indicating capacity on disbursing and utilising funds—also acts as a proxy for district-level capacity development.

¹⁰⁶ ANC (K4, Fe, TT) and PNC (Vit A, Vit K, exclusive breastfeeding, immunisation against Hep B, prevention of PPH and infection)

Program name	Australia–Indonesia Partnership for Health Systems Strengthening	Data source	Comments
		District Health Accounts and National Health Accounts..	
	Output Indicator 2.3		
	<ol style="list-style-type: none"> 1. Number of primary health care facilities with minimum midwives and nurses to provide core services in line with district plan. 2. % of staff in district with agreed job description who receive annual performance appraisal. 3. % of staff in post when they should be. 		Indicator(s) on effective district planning of human resources for health—also acts as a proxy for district-level capacity development.
Output 3	Output Indicator 3.1		
Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in 20 districts in five provinces have empowered and qualified health workers and have sufficient resources to deliver quality, free primary health care services and referral for the poor and the near-poor (Puskesmas achieve Poned status, that is, the management of basic emergency obstetric neonatal care).	<ol style="list-style-type: none"> 1. Reduced out-of-pocket expenditure by poor people attending Puskesmas; OR 2. Benefits incidence of public funding 	Using existing BPS surveys such as annual expenditure survey or <i>Risikesdas</i> .	Measure increased affordability. Option 1 is focused on primary health care; option 2 is whether public funding is benefiting poor people.
	Output Indicator 3.2		
	<ol style="list-style-type: none"> 1. At least X% of Puskesmas meet National Minimum Standards for Health in Kabupaten/Kota (Permenkes 741/2008) for service readiness score for core services. 	Health facility assessment using standardised questionnaires.	Based on WHO HSS indicator. Will include trained staff, guidelines, equipment, diagnostic capacity, medicines etc. so covers availability and quality.
	Output Indicator 3.3		
	<ol style="list-style-type: none"> 1. Proportion of Puskesmas budget from all national and district sources disbursed to Puskesmas each month or quarter 	District Health Accounts, National Health Accounts, routine records, public expenditure tracking survey	Indicator to measure impact of improved capacity on financial management.
Output Indicator 3.4			
	<ol style="list-style-type: none"> 1. Distribution of health workers matches planned allocation for primary health care facilities based on occupation/speciality, geography, demographics. 	District records? Survey	Indicator to measure impact of improved capacity on health workforce management.
Output 4	Output Indicator 4.1		
The Centre for Health Workforce Education and Training (Pusdiklatnakes) ensures that selected government health polytechnics (Poltekkes) run accredited nursing and midwifery study programs (Program Studi Kabinanan Perawat (Prodi)) to produce	<ol style="list-style-type: none"> 1. 5 Poltekkes successfully accredited by 2016 	MoH, MONE and Poltekkes records	
	Output Indicator 4.2		
	<ol style="list-style-type: none"> 1. Annual number of midwife and nursing graduates per 100 000 population from five Poltekkes under new accredited courses. 	Poltekkes records. Other?	Modified from WHO HSS indicator.
Output Indicator 4.3			

Program name	Australia–Indonesia Partnership for Health Systems Strengthening	Data source	Comments
qualified nurses and midwives for the selected primary health care and village health posts.	1. Proportion of annual graduates who take up employment in poor or rural district.	Survey. Government records?	
Output 5	Output Indicator 5.1		
Universities, research institutes and civil society organisations are able to deliver evidence-based data, advocate for health financing and human resources for health with the central and local policy-makers, and provide technical assistance and training to districts and Puskesmas to increase health access for the poor and the near-poor.	1. Number of studies and policy-relevant publications which can show use of the evidence in policy decision-making.	Program records	
	Output Indicator 5.2		
	1. Number of civil society organisations receiving small grant funds for health policy, local health facility accountability and research for health advocacy. 2. Number of advocacy publications, events, press statements by civil society advocating for government attention to health of poor at national, provincial and district levels.	Program records	

Indicators in this framework are drawn from a number of sources, including discussions with the Ministry of Health, the WHO publication ‘Monitoring the Building Blocks of Health Systems: A handbook of indicators and their measurement strategies’, and experience from relevant activities and indicators in the AIPMNH program.

Indicators, baselines and targets will be further developed in the inception and early mobilisation phase.

4 Key points for program inception: monitoring and evaluation

Data sources

The AIPHSS program will allocate 6 per cent of its resources to supporting monitoring and evaluation. The basic principle for this will be to use and strengthen national health information systems as much as possible while reporting against the logical framework. Assessment of the Indonesia health information system conducted in 2007 with support from the Health Metrics Network suggests that the stronger points of the system are in the indicators used and the data sources that are available. These were assessed as ‘present but not adequate’. Particular weaknesses were identified as the resources available and data management; the latter was assessed as ‘not present at all’.

Attachment 1 includes a summary of existing data sources that have been identified as important for program monitoring. The summary explains what those sources cover and their strengths and weaknesses. Between them, they cover a range of health outcomes, health care utilisation, health care financing, health service delivery and socioeconomic status. Sources include the Indonesia Demographic and Health Survey, primary health

research (Riskesdas), the National Socioeconomic Survey (Susenas), the Indonesia Health Profile, programmatic reporting and Jamkesmas and Jampersal reporting.

Baseline data

The AIPHSS program's inception phase will support government to develop appropriate baseline data where it does not presently exist. International expertise in health systems monitoring and evaluation will be sourced to assist in this process. Technical roundtables may also be convened to assist the MoH to develop data collection methodologies, for example, developing consistency between the Riskesdas and Susenas so that socioeconomic profile data can be linked to health behaviours and outcomes. The technical roundtables will include staff from the national statistics agency (BPS).

Potential evaluation questions

The AIPHSS program will support a range of interventions to improve the health of poor people in Indonesia. There will be ongoing feedback within the program to enable the Ministry of Health to learn from the program. In addition, evaluation will be necessary to learn which inputs contributed to achievement of the outputs and outcomes so that they can be replicated in other districts and provinces. It is too soon to identify the most valuable evaluation questions to learn from, but the key evaluation questions could include:

- > comparison between program counties and non-program counties to measure and evaluate capacity development and achievement of outputs and outcomes
- > evaluation of achievement of improved maternal and neonatal health outcomes to understand key factors that contributed to their achievement
- > evaluation of policy initiatives to improve the distribution and presence at the workplace of health workers
- > evaluation of policy initiatives to improve the planning, disbursement and utilisation of health funding and assessment of whether and why they are achieving (or not achieving) their stated health policy objectives.

Monitoring and evaluation expertise

In addition to the monitoring and evaluation staff located in the PMU in the Ministry of Health, the program will make available an internationally recognised expert in monitoring and evaluation to play a supporting role for the program staff. The expert will also ensure consistency in monitoring and evaluation across the whole program and participate in the program Technical Working Group. The monitoring and evaluation expert will support the PMU to monitor and manage the program risks and assumptions. Suggested draft terms of reference are attached.

Attachment 1: Existing data sources to support monitoring and evaluation

Indonesian Demographic and Health Survey—every three years

(The last survey was conducted in 2007.)

The 2007 Indonesia Demographic and Health Survey (IDHS) is a community-based survey carried out by Bureau of Statistics Indonesia (Badan Pusat Statistik—BPS). The 2007 IDHS is the sixth survey conducted in Indonesia under the auspices of the Demographic and Health Surveys program. Most of the data collected in the 2007 IDHS provide updated estimates of basic demographic and health indicators covered in previous IDHS surveys.

The 2007 IDHS is designed to provide information on population, family planning, and maternal and child health. A scientifically selected sample of ever-married women aged 15 to 49 years and currently married men aged 15 to 54 were interviewed. Women were asked questions about their background, the children they had given birth to, their knowledge and use of family planning methods, the health of their children, reproductive health, and other information that is helpful to policy-makers and administrators in the health and family planning fields. The questionnaire for men was shorter than that for women, as it excluded detailed questions on individual children and children's health. It is understood that the 2011 survey will interview all women, not only ever-married women, which will provide more accurate statistics on women's health issues.

Funding for the IDHS came from the following sources:

- > The Government of Indonesia supported local costs of the survey.
- > The United Nations Population Fund provided funds for printing and shipping the questionnaires.
- > Macro International, Inc. provided limited technical assistance under the auspices of the Demographic and Health Surveys program, which is supported by USAID.
- > Other donors provided additional funds to allow other sampling in particular districts and provinces.

Primary health research (Riskesdas)—every three years

(The last comprehensive survey was done in 2007; the 2010 survey was not comprehensive, but only intended to cover MDGs.)

Riskesdas is community-based research whose samples are taken from households and household members that are selected in proportion to the size of the district or city. It is administered by the Ministry of Health (Directorate of Research and Development—Litbangkes). Riskesdas provides basic health information, including biomedical, using the sample frame of the Indonesia Socioeconomic Survey (Susenas). Riskesdas uses a descriptive cross-sectional survey. Riskesdas 2007 includes bigger samples than previous health surveys attached to Susenas and covers broader aspects of health. It uses samples

from 258 366 households and 987 205 household members and measures many public health indicators, for example, under-five nutritional status.

Weaknesses of this research include:

- > It does not include data from newly established districts.
- > Household absence
- > Data was collected at different times.
- > Estimates at district level are not valid for all indicators.
- > Biomedical data only represents urban block census.
- > Currently, it is unable to link up with Susenas data on socioeconomic status of respondents, although this is being addressed.

The last complete Riskesdas survey was conducted in 2007. In 2010 MoH conducted another Riskesdas, but it only covered the MDG indicators.

National Socioeconomic Survey (Susenas)—every year

(The last survey was in 2010.)

The National Socioeconomic Survey (Susenas) is a nationwide survey conducted annually by the National Bureau of Statistics (BPS) to collect information on social and economic indices. It serves as a main source to monitor social and economic progress in the country. It assesses detailed information on basic social and economic issues. The survey covers basic information of household and individual characteristics on health, death, education and literacy, employment, fertility and family planning, housing and household expenditure. Susenas 2007 core covers 285 186 households and is designed to be representative up to the district and municipality levels. In 2007, the data set covers 68 640 households. Since 2007 Susenas does not implement the health module, but rather a more detailed examination of housing and settlement variables. The results of the 2010 survey are now available.

Indonesia Health Profile—every year

(The last profile was in 2010.)

The profile is produced annually by the Ministry of Health (Centre for Data and Information—Pusdatin). Its source of data is facility-based data from provincial and district health offices.

Data consists of the following:

- > the health profile of each district and province, including information on mortality, morbidity and nutrition
- > the profile of health services in each district and province, including information on primary health care, referral services, communicable and non-communicable diseases and nutrition status
- > the profile of the health workforce, including their functions and responsibilities, number and financing.

The profile consists of raw data that is analysed by Pusdatin and technical units within MoH.

Its weaknesses include that:

- > Not all data are up to date and reliable.
- > Facilities and district and provincial health office are still reluctant to provide data to Pusdatin due to local regulation law.
- > There is a lack of coordination between Pusdatin and other technical units.
- > Pusdatin has limited capacity to compile and analyse the data.
- > Due to decentralisation, not all district and cities provide reports to Pusdatin.

Programmatic reporting

Facilities provide quarterly reports to the district health office (DHO); the DHO reports to the provincial health office (PHO) and then to the national-level technical unit, for example, the Health Workforce Unit, Maternal and Child Health Unit.

Flow of reporting

Puskesmas (through facilities health information system) → provide two weekly reports to the DHO *hard copy* → forward to PHO *hard copy/ soft copy* → PHO recaps the data then submits to Directorate of Primary Health Care, MoH/central level at the end of every month—*email*.

The weaknesses of programmatic reporting include:

- > Delay in the submission of the report from facilities automatically affects the reporting from PHO to national level.
- > There is no obligation for a subnational office to submit data to the national level, so the national-level MoH does not always receive the report regularly. However, this has improved in the last two years following the development of MoH policy on the matter.
- > There are problems because of geographic location and infrastructure.

Jamkesmas and Jampersal (responsible unit within MoH: Centre for Health Financing and Social Health Insurance/PPJK)

Jamkesmas

Health facilities (Puskesmas) provide reports monthly through a web-based application and send copies to DHOs and PHOs. To date, the compliance rate is low. In areas where facilities are unable to access the internet, they provide data on utilisation of Jamkesmas through spreadsheets.

Hospitals provide monthly data through a web-based application directly to PPJK and send copies to DHOs and PHOs.

The report consists of:

- > the utilisation rate of Jamkesmas
- > the claim rate
- > disease patterns.

PPJK is currently working on the utilisation rate of Jamkesmas for 2010.

Jampersal

The process is same as above but with different coding to the Jamkesmas.

Annex 10: Program implementation schedule

Introduction

Program implementation will begin in 2012 and continue until June 2016. The program implementation schedule is based on an assumption that the AIPHSS program will be formally approved by AusAID and the Ministry of Health (MoH) in August and September 2011. The schedule is outlined by quarter according to Australian financial years. The end date is 30 June 2016.

The AIPHSS program will become fully operational when the Program Management Unit (PMU) is established in the MoH and when an Implementing Service Provider (ISP) is hired. This is anticipated to occur by 1 July 2012.

During the period until the PMU and ISP become fully operational, it will be important to maintain the positive momentum between the MoH and AusAID that was experienced during the design phase. This period will be referred to as the inception phase. By necessity, a number of activities will need to be completed during the inception phase, in preparation for implementing the AIPHSS program on 1 July 2012.

Critical activities during the inception phase

Establishment of management, governance and oversight structures

Because the implementation of the AIPHSS program will be led by the MoH, AusAID will work closely with MoH officials during the inception phase to establish the necessary governance, oversight and administration arrangements at the national, provincial and district levels. These include establishing the PMU, the Technical Working Group and the Program Steering Committee, along with all associated recruitment. It will involve the issuance of ministerial and other instructions.

AusAID will provide short-term technical inputs to the PMU to assist its preparation of the necessary implementation tools. These include, for example, the program implementation manual, procurement and disbursement plans and a performance-based framework.

During the inception phase, AusAID will undertake the tender process for the ISP. This should take approximately six months. Concurrently, AusAID will recruit the Program Technical Specialist and the Monitoring and Evaluation Adviser for the AIPHSS program.

Fiduciary risk and capacity assessments

Global Fund processes will form the basis for program implementation arrangements, noting that some modification will be required because AusAID, unlike the Global Fund, has an in-country presence. AusAID will be using the Global Fund Local Fund Agent (PricewaterhouseCoopers) and it will be necessary to undertake further fiduciary risk and capacity assessments to determine the capability of the MoH's Bureau of Planning and Budgeting to lead and manage the AIPHSS program.

These assessments will take place during the inception phase before the grant agreement is finalised, to prepare for the start of program activities in 2012. Among other things, they will evaluate the procedures outlined in the program implementation manual, procurement and disbursement plans and the performance-based framework developed by the PMU.

The outcome of the fiduciary risk assessments will feed into the formulation of the grant agreement and a risk management plan for the AIPHSS program.

District selection

Selection of districts in the first two participating provinces, East Java and Nusa Tenggara Timur (NTT), will be made jointly by AusAID and the MoH during the inception phase. The criteria for district selection are:

- > Districts are ranked as poor.
- > Districts perform poorly on key health indicators.
- > Preference will be given to districts where the program can capitalise on existing AusAID support (especially in NTT with the Australia–Indonesia Partnership for Maternal and Neonatal Health and the Australia–Indonesia Partnership for Decentralisation).
- > District leadership demonstrates the political will to improve health systems (measured by the level of funds allocated to health, and evidence of a history of systems strengthening).
- > Districts are aligned to districts where the Global Fund HSS program works.
- > Districts provide examples for scaling up.

Participation of East Java and NTT has been agreed in principle at the level of Head of Provincial Health Office. District participation will be subject to the agreement of districts and a formal letter of support.

Annual work plan 2012–13

In future years of the program, the PMU and ISP will be responsible for developing prioritised and budgeted annual work plans in consultation with subnational stakeholders. The activities will be initiated at the district level, and the preparation of annual work plans will be aligned with the Government of Indonesia's budget cycle and planning processes.

To align with the Government of Indonesia's budget process for 2012–13, the first annual work plan will need to be finalised in the inception phase and will cover the period from July 2011 to December 2013. AusAID will provide short-term technical inputs to the MoH during the inception phase to assist completion of the first annual work plan. This

process will follow the process for development and approval and review of annual work plans set out in Annex 6. Criteria for the selection of program activities for 2012–13 will be agreed with the MoH. To be included in the selection, activities should:

- > be essential and necessary to achieve outputs and targets.
- > build on the lessons learned from other programs and demonstrate continuous improvement.
- > be consistent with international evidence in health systems strengthening.
- > build institutional systems and capacity
- > not be funded through other Government of Indonesia sources, although it is possible that government funding does not always deliver a timely quality product. Therefore it may be necessary to:
 - identify if a government entity is formally supposed to be providing the intervention (for example, training). If so, we must consider what factors are inhibiting its quality and delivery and how we can address the shortcoming
 - in the case where there is no entity formally required to provide the intervention but it is needed on an ongoing basis, we must consider how the program can help the government to recognise the need formally and support the intervention’s establishment.

More detail on proposed program activities can be found in Annex 6.

During the inception phase an assessment will be undertaken of the programmatic and operational links with the Global Fund HSS project to strengthen health information systems.

Negotiation of grant agreement

Disbursement of funds to the MoH will be via a single grant agreement. The negotiation of the grant agreement should take place during the inception phase, following receipt of the fiduciary assessment by the Local Funds Agent, and be completed in time for the start of the AIPHSS program on 1 July 2012.

Monitoring and evaluation

There are a number of activities related to monitoring and evaluation that will be completed during the inception phase. Where necessary, AusAID will provide short-term technical support to the MoH to assist in these activities.

Following approval of the AIPHSS program design, it will initially be necessary to finalise the logical framework. Specific activities include reaching agreement on the indicators, targets, baselines and milestones for the program.

It will also be necessary to conduct an evaluability assessment, develop a monitoring and evaluation plan and collect baseline data. These activities will need to be concluded by the start of the program on 1 July 2012.

Further detail on monitoring and evaluation is at Annex 9.

Program Implementation Schedule		2011	FY 2011-2012				FY 2012-2013				FY 2013-2014				FY 2014-15				FY 2015-16				
	By whom	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Program Design	AusAID & MOH																						
Program Approval	AusAID & MOH																						
Signature of bilateral agreement (SA)	AusAID & MOH																						
Negotiations with Global Fund	AusAID, GF & MOH																						
Program Inception	MOH & AusAID																						
Fiduciary Risk Assessment PMU	AusAID																						
Signature of grant agreement with MOH and establish PMU	MOH																						
Recruit PMU Manager	MOH																						
Recruit Program Technical Adviser	AusAID																						
Program Launch	All																						
Tender for ISP	AusAID																						
ISP selected	AusAID & MOH																						
Recruit M&E adviser	AusAID																						
ISP launched	ISP																						
TWG Meeting	PMU																						
Steering Group meeting	MOH / PMU																						
Annual Workplan approved	SC / PMU / ISP																						
Implementation of workplans	PMU / ISP																						
Evaluability Assessment undertaken and M and E Plan developed	PMU / ISP																						
Gender Plan developed	PMU / ISP																						
Develop Policy Communications Plan	PMU / ISP																						
Financial Management training	PMU / ISP?																						
Develop Financial Management Plan	PMU / ISP																						
Baseline data gathered	PMU / ISP																						
Endline surveys	PMU / ISP																						

Annex 11: Draft position descriptions and terms of reference

Introduction

This annex outlines the role and responsibilities of the Implementing Service Provider and includes three draft documents as attachments:

1. Draft terms of reference for the Implementing Service Provider
2. Draft terms of reference for the Program Technical Specialist
3. Draft terms of reference for the Monitoring and Evaluation Adviser.

Role and responsibilities of the Implementing Service Provider

Lead accountability for managing and implementing the AIPHSS program lies with the Program Management Unit (PMU) in the Ministry of Health. However, AusAID will contract an Implementing Service Provider (ISP) to provide support to the PMU in implementing the program.

The ISP manager will operationally report directly to the PMU. It will provide annual reports and work plans to AusAID and the Program Steering Committee and report financially to AusAID. The ISP will work in close consultation with the PMU and the Technical Working Group. It is expected that the ISP manager will meet on a monthly basis with the PMU manager, the Program Technical Specialist and the Monitoring and Evaluation Adviser to ensure coordination between activities.

The ISP will be responsible for managing two distinct components of the program. The first component relates to the provision of demand-driven technical assistance, training and capacity building. This component will require the ISP to work with the PMU to develop annual work plans of technical assistance and training that meet the PMU's needs. The ISP will provide flexible resources for the program and will assist it to respond to emerging health policy and systems issues. The ISP will also provide monitoring and evaluation assistance to the AIPHSS program and evaluate such assistance. The annual work plans will be reviewed by the Technical Working Group and endorsed by the Program Steering Committee.

The second component relates to the development and establishment of a Health Policy Network of Indonesian universities and research institutes, and the establishment of a Civil Society Challenge Fund.

In relation to both components of the program, the ISP must ensure that it is at all times responsive to the Government of Indonesia's needs. The ISP must also support the Ministry of Health to ensure that the AIPHSS program maximises opportunities to promote gender equality, for example, by collecting sex-disaggregated data to inform

policy, including gender analysis in service delivery and identifying and addressing issues that disproportionately affect women and girls.

The ISP must also link with other AusAID investments, including in the knowledge sector and in relation to building capacity of civil society.

The Health Policy Network will (a) conduct research about poor people and their need for and access to health care; (b) learn lessons from program implementation for policy-makers; and (c) provide technical assistance for the implementation of district activities. For the ISP, managing the implementation of this component may involve:

- > undertaking institutional assessment for a Health Policy Network. This could include international collaboration
- > finalising terms of reference for the Health Policy Network and the implementation mechanism
- > establishing a monitoring and reporting framework for the Health Policy Network
- > managing a competitive grants round to develop innovative research methodologies and a stronger critical mass of research in the area of access to primary health care for poor people
- > funding health policy think tanks, meetings and workshops, roundtables and policy meetings to disseminate results to bring evidence to policy—especially in the area of maternal and neonatal health
- > providing funding and technical assistance to:
 - develop capacity to develop policy and present evidence to policy-makers
 - undertake research in key identified areas (for example, poverty and poor people) to link with the planning for the next national health strategic plan
 - develop stronger regional health policy research capacity in institutes that can support policy-making in provincial and district health offices
- > funding a Health Policy Network hub in the Ministry of Health that provides analysis and advice to the Ministry.

The Civil Society Challenge Fund will support selected civil society groups to (a) develop capacity to respond to and demand better pro-poor health policy; (b) hold health offices and primary health care providers accountable for the services they provide; and (c) conduct research to inform health advocacy and policy. In the medium term the Civil Society Challenge Fund may evolve to support the establishment of a civil society network or umbrella organisation to help organise and coordinate participation of civil society organisations in health policy discussions.

The ISP will therefore be responsible for the development and establishment of the Civil Society Challenge Fund in close consultation with the PMU and the Technical Working Group. This will involve:

- > agreeing on the scope and terms of reference for the Civil Society Challenge Fund
- > managing the development and implementation of the Civil Society Challenge Fund.

In relation to both components of the program, it is expected that the ISP will link wherever possible with UN Development Programme's Management and Technical Assistance Facilities, which aim to strengthen the implementation of Global Fund grants in Indonesia.

The ISP's administrative responsibilities for both components of the AIPHSS program may include:

- > preparation of terms of reference and position descriptions for all technical assistance positions
- > preparation of contracts for personnel recruited
- > logistics associated with mobilisation and demobilisation of recruited personnel
- > payroll of technical assistance and contracted staff
- > payment for all procured goods and services
- > payment, monitoring and acquittal of grants
- > implementation of a monitoring and evaluation system for both components of the program that is integrated into the overall monitoring and evaluation plan for the program
- > supporting the Ministry of Health to ensure that the program is responsive to gender issues, including through the provision of technical assistance to assist the implementation of the Gender Action Plan and to conduct specific activities in support of improved gender equity
- > carrying out ad hoc activities as requested by AusAID relating to the program.

The specific deliverables for each component of the AIPHSS program are outlined in greater detail in the draft ISP terms of reference in Attachment 1. The scope of services and basis of payment for the ISP will be released with the tender documents.

Attachment 1: Terms of reference for Implementing Service Provider

Background

AusAID leads the Australian Government's aid program delivered to Indonesia. Responsibility for program implementation has been devolved to the Country Office in Jakarta. The aid program is guided by the Australia–Indonesia Partnership Country Strategy 2008–13, which has identified priority areas of infrastructure, education, health, governance and disaster management.

AusAID's current engagement in health subsectors in Indonesia is well targeted to assist Indonesia to meet its MDG targets. The current Indonesia health portfolio consists of maternal and neonatal health, HIV/AIDS and emerging infectious diseases (animal health and human health) programs. Globally, there is renewed recognition of the need for development assistance to strengthen health systems to complement vertical disease-based programs. AusAID's proposed Australia–Indonesia Partnership for Health Systems Strengthening (AIPHSS) sprang out of a need to improve some of the systems challenges that hinder the delivery of better primary health care for the poor in order to maximise its impact and to meet the challenge of achieving the MDGs.

The intended impact of the program is improved health outcomes of poor people. The outcome is improved utilisation of quality primary health care and appropriate referral by the poor and near-poor to achieve the health MDGs (in 20 districts in five provinces). The program will be implemented for five years from 2011 to 2016 with a total budget of \$50 million.

The AIPHSS program will be partially harmonised with a Global Fund HSS grant of \$37 million over five years.

The AIPHSS program will be delivered through two forms of aid. First, grant funding will be provided to the national Ministry of Health for implementation of national and district activities, to be managed by a Program Management Unit (PMU) in the Ministry of Health. Second, technical assistance and capacity building will be provided by an Implementing Service Provider (ISP) contracted by AusAID. The ISP will support a Health Policy Network of Indonesian universities and regional schools of public health and health management. The ISP will provide technical assistance and training and will be a flexible resource to respond to emerging health policy and systems issues. The Health Policy Network will conduct research on poor people and their need for and access to health care, learn lessons from program implementation for policy-makers, and provide technical assistance for the implementation of district activities.

Expected deliverables and responsibilities

The ISP will be responsible for two distinct components with the following deliverables:

Component 1

1. Provide technical assistance and training to support the PMU in the delivery of its outputs.
2. Develop an annual work plan of technical assistance and training that responds to the needs and demands of the PMU, for approval by the Program Steering Committee.

3. Provide an annual report to the PMU, the Program Steering Committee and AusAID on ISP performance and activities.
4. Develop a performance framework for monitoring all ISP activities.
5. Take over the funding and contracting of the Monitoring and Evaluation Adviser from AusAID.

Component 2

Health Policy Network

1. Conduct analysis of existing university and research institutes and develop a concept note for the Program Steering Committee on the scope, purpose, deliverables and activities for a Health Policy Network.
2. Manage a tendering process for Indonesian universities and research institutes to develop a Health Policy Network.
3. Provide annual reports to the Program Steering Committee on the Health Policy Network.

Civil Society Challenge Fund

1. Develop a concept note for the Program Steering Committee on the scope, purpose, deliverables, grant type and size, criteria for funding, and funding decision-making process for a Civil Society Challenge Fund. The ISP will need to conduct analysis of existing civil society organisations' capacity and current role in advocating for health funding, advocacy to inform health policy and capacity for holding district health departments and health facilities to account.
2. Manage the Civil Society Challenge Fund.
3. Provide annual reports to the Program Steering Committee on the Civil Society Challenge Fund.

Skills and competency required

The ISP will be required to demonstrate the following skills and competencies:

1. experience in the provision of technical assistance in support of a government-led health systems strengthening program
2. strong health systems expertise, in particular in the fields of health financing; human resources for health; and health planning, budgeting and management at the district level in decentralised health care systems
3. experience in supporting health research and health policy analysis
4. experience in supporting civil society organisations' engagement in health policy processes and accountability of health offices and health care providers
5. health information systems expertise, including national-led surveys, routine health information systems and related health systems strengthening program monitoring and evaluation.

Attachment 2: Terms of reference for Program Technical Specialist

Background

AusAID leads the Australian Government's aid program delivered to Indonesia. Responsibility for program implementation has been devolved to the Country Office in Jakarta. The aid program is guided by the Australia–Indonesia Partnership Country Strategy 2008–13, which has identified priority areas of infrastructure, education, health, governance and disaster management.

AusAID's current engagement in health subsectors in Indonesia is well targeted to assist Indonesia to meet its MDG targets. The current Indonesia health portfolio consists of maternal and neonatal health, HIV/AIDS and emerging infectious diseases (animal health and human health) programs. Globally, there is renewed recognition of the need for development assistance to strengthen health systems to complement vertical disease-based programs. The AIPHSS program sprang out of a need to address some of the systems challenges that hinder the delivery of better primary health care for the poor in order to maximise the impact and meet the challenge of achieving the MDGs.

The AIPHSS program will be delivered through two forms of aid: first, through grant funding to the national Ministry of Health for implementation of national and district activities; and second, through an Implementing Service Provider (ISP) contracted by AusAID. The ISP will provide technical assistance and training and will be a flexible resource to respond to emerging health policy and systems issues. The ISP will establish and support a Health Policy Network of Indonesian universities and regional schools of public health and health management and a Civil Society Challenge Fund. The Health Policy Network will conduct research on poor people and their need for and access to health care, learn lessons from program implementation for policy-makers, and provide technical assistance for the implementation of district activities.

Roles and responsibilities

AusAID is seeking to engage an experienced and highly motivated person to fill the role of Program Technical Specialist (PTS) for the AIPHSS program. The PTS will be responsible for providing technical advice in the planning and implementation of the AIPHSS program so that it contributes to the implementation of the Government of Indonesia's policy on the country's health workforce and health financing, and to the decentralisation of planning.

In doing so, the PTS will provide inputs to the Program Manager in the Ministry of Health Program Management Unit (PMU).

The PTS will report to the Program Manager located in the Ministry of Health.

The PTS will be directly contracted by AusAID through a trusted hiring company and will be located in the AIPHSS PMU in the Ministry of Health, Jakarta. Key characteristics of the role are:

- > expertise in health policy, particularly in health systems strengthening
- > Indonesian development experience, preferably in the health sector
- > Bahasa Indonesian language skills

- > two-year contract with possible three-year extension subject to satisfactory performance
- > annual 360° performance assessment administered by AusAID.

The program will require consistent, high-level technical inputs and liaison between Ministry of Health counterparts in several technical divisions, universities, civil society and development partners to promote effective primary health care policy and implementation. It is necessary that the PTS present a clear and consistent position on primary health care policy and health systems strengthening. The role involves facilitating strengthened communication and collaboration between the national and subnational levels of government to improve policy and program outcomes, and supporting the PMU in ensuring that ISP inputs meet the needs of the program participants at the national, provincial and district levels. This will involve significant periods of time visiting the provinces and districts in which the program will be operating.

Duties will include the following:

- > assisting the Program Manager in coordination and presentation of the Annual Activity Plan to AusAID and the Ministry of Health for funding commitment and the Program Steering Committee for approval
- > identify, together with the Program Manager, additional capacity-building assistance required to facilitate the effective operation of the program governance and management bodies
- > ensure that activities delivered by the ISP and PMU are consistent and mutually reinforcing
- > monitor and provide feedback to the ISP on technical assistance to ensure that it meets program needs
- > support the Program Manager to prepare six-monthly reporting to the Technical Working Group and Program Steering Committee
- > through the Program Manager, assist subrecipients of program grants to develop plans of action as required
- > ensure that plans of action are aligned with the Ministry of Health's priorities and consistent with international best practice
- > provide technical advice in international best practice on health systems strengthening to the Ministry of Health
- > assist and mentor staff from the Ministry of Health to identify ways to improve their health systems.

It is acknowledged that no individual technical specialist has the capacity to address all the technical issues that are likely to arise from the program focal areas and the AIPHSS. Therefore, the PTS will need to be empowered to commission AIPHSS programming support directly from the ISP following consultation with the Program Manager. All programming support will need to be separately identified and reported in quarterly reporting, with the PTS and Program Manager providing the oversight and performance reporting on these inputs to the program.

The PTS will not represent AusAID in decision-making with the Government of Indonesia. Separately from the PTS, AusAID will be represented on all governance

structures and at all decision-making with the Government and stakeholders to ensure policy consistency and a suitable level of representation with those stakeholders. This is especially important if the scope of the program changes, or resourcing needs to be increased where implementation is accelerated.

Attachment 3: Terms of reference for Monitoring and Evaluation Adviser

The AusAID Indonesia program has standard terms of reference for monitoring and evaluation specialists. These will need to be adapted for a government-led health systems strengthening program and agreed with the Program Manager of the Program Management Unit.

Key deliverables and requirements from the monitoring and evaluation adviser for the AIPHSS program

The Monitoring and Evaluation Adviser will report to the Program Manager of the Program Management Unit (PMU). (These terms of reference will be agreed with the Program Manager.)

The Monitoring and Evaluation Adviser will be responsible for:

1. supporting the PMU in finalising the program's logical framework, including an evaluability assessment, and agreement on all indicators, baselines, milestones, targets and data sources
2. liaising with the Global Fund HSS program, which has a strong health information system component, and ensuring that there is strong synergy and no duplication with Global Fund-supported health information system activities. Consideration should be given to shared indicators between Global Fund, AusAID and GAVI Alliance funded HSS initiatives.
3. supporting the PMU and Ministry of Health to identify all data sources and any capacity issues or additional data sources or surveys required to report on program performance
4. leading and supporting the development of a monitoring and evaluation capacity development plan to ensure that all required data can be generated and analysed
5. supporting the PMU to commission technical assistance, training and capacity building to strengthen and improve, as required, national surveys or health information systems
6. supporting the PMU in commissioning from the ISP specific additional international expertise and best practice to strengthen health information systems (avoiding duplication with Global Fund HSS program)
7. assuring the quality of annual performance reports against the logical framework
8. supporting the generation and analysis of baseline and endline data.

AusAID Indonesia standard example terms of reference for a monitoring and evaluation (M&E) specialist for a significant initiative

Version: November 2010

Note: These terms of reference are generic and for guidance purposes only. Specific requirements for individual initiatives will need to be incorporated into the final terms of reference.

1. Qualifications

The consultant should hold a postgraduate degree that has included a research dissertation component. Alternatively, evidence of training in advanced research or evaluation design, conduct and management. Short professional development courses in M&E are not considered advanced training.

Where a post graduate degree in research or evaluation methods has not been completed, evidence of the quality of research or evaluation activities previously designed and conducted should be sought.

2. Experience

Essential

2.1 Experience developing M&E systems for programs in resource-constrained settings (domestic or international). This is required to ensure that the proposed M&E systems are feasible in the context, and are focused on decision-making or applied research rather than basic research (unless otherwise stated).

2.2 Demonstrated practical experience in research or evaluation design, conduct, and management. This experience should reflect expertise in developing a fully elaborated design of an M&E system that includes the design approach, articulation of M&E questions, development of sound methods and tools, conduct of data collection and analytical techniques (or supervision of such), interpretation and dissemination of results and report preparation. It is not considered adequate experience to have designed an M&E framework or plan without having completed the implementation of the evaluation activity cycle.

2.3 Demonstrated ability to break down and communicate complex concepts simply with a range of stakeholders in multicultural settings. Findings and their interpretation must be communicated in a simple, easy-to-digest format for program decision-makers.

2.4 Demonstrated ability to facilitate learning from M&E findings with implementation teams and other relevant stakeholders. This could include building the capacity of the implementation partners to respond to evaluation findings where appropriate.

Desirable

2.5 Demonstrated experience in the delivery of development programs. This is relevant as it may ensure that the consultant is sensitive to the difficulties of implementing human development programs in complex settings, that the design is feasible and provides value for money, and that the M&E systems meet the needs of all relevant stakeholders.

2.6 Demonstrated ongoing membership of a domestic or international evaluation society, or other demonstrated commitment to keeping up to date with the theoretical and practice developments in the field of evaluation.

3. Terms of reference

3.1 Conduct an evaluability assessment at a time when the implementation team and partners are ready and able to clearly articulate the outcomes and interventions of the initiatives. The M&E specialist is expected to be familiar with this form of assessment (see Annex A for a guide on the scope of an evaluability assessment).

- 3.2 Develop a design for an impact evaluation of the program.
- 3.3 Using a participatory approach, design a monitoring and evaluation plan that meets the expectation of AusAID and international standards of practice in M&E. AusAID standards are available from program managers, while international standards could include the DAC Evaluation Quality Standards or the Joint Committee Standards.
- 3.4 Identify where the implementation team will require ongoing M&E technical support, and where they will be expected to implement the M&E plan themselves. (Unless a suitable rationale is provided, the role of the M&E specialist is not to train contractor or other implementation teams in higher-level M&E activities such as evaluation design, the conduct of higher level qualitative methods, or data analysis.)
- 3.5 Describe what capacity is required by the implementation team to implement the M&E plan, and ensure that responsibilities are allocated to individuals with suitable qualifications, experience, and time within their other work demands.
- 3.6 Provide regular support to the implementation of the M&E plan (according to the resourcing provided in the initiative design document). The focus ought to be on the ongoing design of M&E activities, assuring the quality of M&E activities, and conducting or providing direct technical advice for the analysis and interpretation of data.
- 3.7 Supervise the compilation of initiative progress reports that meet the requirements of AusAID and other primary users of the findings and conclusions. An evidence-based, timely contribution to the Quality at Implementation Reports and Activity Completion Reports should be prepared. Negotiation of suitable content and presentation of reports should be part of the evaluability assessment described in Annex A. Reports must reflect an analytical contribution where: a) the findings are described; b) the factors accounting for the findings explored; c) the implications of findings are clearly stated; and d) the management responses already taken are described or recommendations made for future action.
- 3.8 Prepare relevant information in advance of any review team missions.
- 3.9 Contribute to the intellectual development of the initiative during implementation. Working as a facilitator, support the implementation team and other relevant stakeholders to interpret and respond to M&E findings over the life of the initiative.
- 3.10 In consultation with AusAID and the contractor, develop the methodology for the collection and analysis of data on the contractor performance indicators where relevant. (If there is a supervisory team such as a Program Monitoring and Support Group, then this could be carried out by the M&E specialist on that team.)

Annex A: Recommended scope of an evaluability assessment

Monitoring and evaluation specialists are given a fair degree of freedom to design and conduct the evaluability assessment in the manner they consider the most appropriate. The scope of the assessment will be determined by the amount of resources that have been allocated. Despite this flexibility, the M&E specialist must provide a strong basis for the design of the M&E system (that is, the M&E plan).

It is recommended that approximately 10 days' input from the M&E specialist is required to conduct the following minimum requirements:

1. Consult with stakeholders to confirm a shared interpretation of the expected long-term and end-of-program outcomes, and establish an agreed logic model or theory of change for the initiative. Where a logic model or theory of change cannot be developed, a clear rationale is provided, and an action plan proposed for when it may be possible.
2. Prepare a summary logic model of the initiative that can be easily understood by someone not familiar with the initiative. This could include a summary logic model on a single page, supported by a series of more detailed logic models for the major components of the initiative.
3. Identify the reporting requirements for primary information users. This includes initiative-level progress reporting and AusAID Quality at Implementation reporting. There should be a clear description of where the M&E system will provide evidence for reporting against the Country Program or Sectoral Performance Assessment frameworks.
4. Identify key evaluation questions of interest to primary information users. These questions could assess the factors that may have influenced the adequacy of progress toward the end-of-program outcomes, or test any important or unproven theories of change.
5. Prepare a review of cross-cutting policy areas that will need to be included in the M&E plan such as gender, environment, anti-corruption, or environmental outcomes.
6. Review the financial, human and material resources available for M&E activities.
7. Examine proposed or potential existing data sources (including partner systems) to ensure that data is of sufficient quality, is collected and analysed as expected and will be available within the required reporting cycles.
8. Assess the capacity of the implementation team and/or partners to participate in the design and/or conduct of M&E activities.
9. Clearly identify issues and/or constraints that will affect the design of the M&E plan.

Annex 12: Risk analysis and risk management

This annex summarises the analysis of the key risks to successful implementation of the AIPHSS program. It includes an assessment of the probability of the risk occurring, the likely impact should the risk occur, and measures that can be taken to manage the risk.

Alternative arrangements for implementation exist, should there be shifts in levels of support as a result of political changes or should the alignment with Global Fund mechanisms prove problematic. Risk registers developed by AusAID and the Program Management Unit at the commencement of the program will address these risks. The Program Steering Committee will be responsible for monitoring program performance, including performance of subrecipients. Criteria will be developed to assist them in determining where program activities should cease due to insufficient progress; lack of political commitment; or cases of nepotism, collusion or corruption. AusAID grant agreement with the Ministry of Health will also set out mechanisms to address underperformance or corruption. An agreed statement of working arrangements with the Global Fund will also be developed in the inception phase.

The national Program Management Unit will develop a risk register in the first six months of the program for approval by the Program Steering Committee. This risk register will outline the risks, the level of probability, potential impact, and risk management strategies. The risk register will be updated biannually to monitor risks, identify emerging risks, and update risk management strategies. The Program Steering Committee might consider identifying owners of each of the risks among the committee to give high-level leadership to risk management.

Table A12.1 outlines the general and program-specific risks and strategies to manage those risks.

Table A12.1: Risks and risk management strategies

	Risk	Probability	Impact	Comments and risk management strategies
General risks	There are reports of misuse or wastage of Ministry of Health funds.	High	High	<ul style="list-style-type: none"> > Ringfencing of AusAID funds to avoid contamination. > Identification of a mechanism to deal with allegations of funds misuse with the Ministry of Health.
	Government commitment to financing universal coverage and strengthening health systems is not sustained.	Low	High	<ul style="list-style-type: none"> > Selection of districts uses criteria of local commitment to health and health systems strengthening. > Program supports research and evidence to advocate for sustained health funding for the poor.
	National policy-making processes do not use evidence from research and health systems programs in districts to inform future policies and policy implementation.	Medium	Medium	<ul style="list-style-type: none"> > Program works to create demand for evidence and to improve the supply by increasing the quality, relevance and accessibility of the evidence. > Program develops a communications strategy which involves multiple channels of disseminating evidence including health officials, researchers, civil society, parliamentarians, and the media. > Program also supports advocacy of evidence from different levels of government, civil society to decision-makers.
Program-specific risks	Mutasi at district level (in particular) limits the potential for technical assistance and training to lead to sustainable improvements in health planning, budgeting and service delivery.	High	High	<ul style="list-style-type: none"> > Capacity building and technical assistance develop systems and skills in offices and individuals. > Program operates in a sufficient number of districts to spread risk so that at least significant majority unlikely to suffer serious mutasi. > Program identifies options for managing the risk of mutasi and advocating for policy changes.
	Program Management Unit does not increase national ownership.	Low	High	<ul style="list-style-type: none"> > AusAID ensures all elements of strategic decision-making are conducted jointly. > Clear description of roles and responsibilities of Program Management Unit and its accountability with the Ministry of Health are agreed at program outset.
	There are reports of misuse or wastage of AusAID or Global Fund HSS funds in Indonesia.	Med	High	<ul style="list-style-type: none"> > Comprehensive fiduciary risk assessment. > Clear agreement on financial management rules and controls at program outset in the program implementation manual. > Contingency plan developed to freeze and recover assets if required. > Agreement with Global Fund on expectations and ways of working. > Contingency plan for alternative funding arrangements should Global Fund mechanism fail > Semi-annual verification of implementation and annual on-site data verification conducted by the Local Fund Agent. > Annual audit.
	National-level oversight of provinces and districts is weak.	Medium	Medium	<ul style="list-style-type: none"> > Oversight and monitoring arrangements agreed at outset to ensure national involvement. > Program designed to link to national Ministry of Health interests and thereby increase stake on program success.
	Capacity in district health offices remains weak.	Medium	High	<ul style="list-style-type: none"> > Program develops framework for assessing capacity of district health offices and uses this to monitor capacity development and raise alarm if insufficient progress is evident.

Risk	Probability	Impact	Comments and risk management strategies
Universities and civil society develop poor-quality research and provide poor-quality technical assistance.	Low	Low	<ul style="list-style-type: none"> > AusAID-contracted resource facility provides technical assistance to university and civil society researchers in research and in presenting findings in accessible format for policy-makers.
Risks of diluting policy dialogue if Global Fund presence and influence is greater.	Low	Low	<ul style="list-style-type: none"> > Program Steering Committee is AusAID-specific oversight mechanism providing high-level forum for dialogue. > AusAID has strong in-country presence and will coordinate with Global Fund including through Country Coordinating Mechanism.
Program leadership of different components is uncoordinated.	Low	Medium	<ul style="list-style-type: none"> > Program management team comprising managers of each key component meets monthly with terms of reference to coordinate. > Program Steering Committee terms of reference include oversight to ensure all program components are contributing to the shared outcome.
The absorptive capacity of the Program Management Unit (at all levels if they are established) or of provincial and district health offices is limited.	Medium	High	<ul style="list-style-type: none"> > Technical oversight on quality of Program Management Unit provided by Program Technical Specialist. > Program Management Unit staff are employed for provincial and district health offices.
Changes in the political economy across the sector (across all levels of government and legislature).	Low to medium	High	<ul style="list-style-type: none"> > Stronger links between MoH and AusAID delivered through the program enable changes to be anticipated and the program to adapt accordingly. > Fallback options include shift in program emphasis from national to subnational or vice versa. > Program Steering Committee to develop criteria for pull back from areas where the program is not progressing. > At subnational level, alignment with Australia–Indonesia Partnership for Decentralisation provinces and districts gives additional leverage. > Presidential decree that requires all districts to give written undertakings prior to receiving program grants.
Planning processes do not result in the selection of appropriate or effective activities and as a result implementation is not effective in achieving program outcomes	Low	Medium	<ul style="list-style-type: none"> > The role of Program Technical Specialist reduces the risk and ensures that effective activities are selected for implementation. > National Program Management Unit will continue to provide significant resources to build capacity for improved data analysis, prioritisation and preparation of medium-term strategic and investment plans as a basis for annual work plans and selection of activities. > Work plans will be subject to approval by Program Steering Committee.
The establishment of the Program Management Unit (mechanism) encounters delays that affect implementation.	Medium	High	<ul style="list-style-type: none"> > Clarity between AusAID and Ministry of Health on roles and responsibilities and timelines on recruitment of staff to Program Management Unit and early agreement on respective roles in recruitment of Program Management Unit staff in districts and provinces. > Close coordination between AusAID and Ministry of Health during the establishment process
Delays in negotiations and signing of subsidiary arrangement and grant agreement.	Low	High	<ul style="list-style-type: none"> > Discussions on subsidiary arrangement already commenced in June 2011 with relevant Ministry of Health directorates. > Continued close coordination between AusAID and Ministry of Health during this process.

	Risk	Probability	Impact	Comments and risk management strategies
	Ineffective use of resources due to a lack of cooperation between MoH, other relevant ministries and subnational government partners.	Medium	High	<ul style="list-style-type: none"> > Program Steering Committee provides clear direction to all levels of government on program implementation and is a mechanism through which to identify issues with cooperation that affect use of resources. > Role of the Program Technical Specialist (as identified in the terms of reference) will include early identification of cooperation issues that may affect use of resources. > Role of Technical Working Group to ensure consistency between AusAID AIPHSS and Global Fund HSS programs and ensure HSS grants are aligned with Ministry of Health priorities.
	Improvements in primary health care services are not recognised by poor people and there is no change to demand.	Low	Low	<ul style="list-style-type: none"> > AIPHSS program will work, where possible, in the same provinces and districts as the Australia–Indonesia Partnership for Decentralisation, which has a strong focus on generating demand for health services. > Work in Vice President’s office to better target Jamkesmas to lower two income quintiles. > PNPM Generasi Conditional Cash Transfers to be rolled out nationally from 2012.

Abbreviations and glossary

AIP	Australia–Indonesia Partnership
AIPHSS	Australia–Indonesia Partnership for Health Systems Strengthening 2011–2016
AIPD	Australia–Indonesia Partnership for Decentralisation
AIPMNH	Australia–Indonesia Partnership for Maternal and Neonatal Health
Askeskin	Basic Health Insurance for the Poor Program (operated by PT ASKES)
AusAID	Australian Agency for International Development
BAPPEDA	Badan Perencanaan Pembangunan Daerah (subnational level national planning agency)
BAPPENAS	Badan Perencanaan Pembangunan Nasional (National Development Planning Agency)
BOK	Bantuan Operasional Kesehatan (Block Grant Program)
BPS	Central Bureau of Statistics
CPR	Chief Principal Recipient
DAU	Dana Alokasi Umum (General Allocation Fund: government funds provided from Ministry of Finance to district governments to fund public services; mainly covers operational costs)
DAK	Dana Alokasi Khusus (Special Allocation Fund: government funds provided from line ministries to district governments to primarily fund public infrastructure/equipment—requires 10 per cent local counterpart funding, generally from DAU support)
Debt2Health Swap	Australia forgoes repayment of debt owed in return for investment in Global Fund–approved tuberculosis programs in Indonesia
DHA	district health accounts
DHO	district health office
FAO	Food and Agriculture Organization of the United Nations
GAHSI	Gender Analysis of the Health Sector for Indonesia
GAVI	Global Alliance for Vaccines and Immunisation
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
Global Fund HSS	Global Fund grant for health systems strengthening
GNI	gross national income
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HSS	health systems strengthening
IDHS	Indonesian Demographic and Health Survey
IFLS	Indonesian Family Life Survey
ISP	Implementing Service Provider
Jamkesda	Jaminan Kesehatan Daerah (Basic Health Insurance for the Poor Program operated by district governments/ district health office)
Jamkesmas	Jaminan Kesehatan Masyarakat (Basic Health Insurance for the Poor Program (operated by Ministry of Health)
Jampersal	Jaminan Persalinan (Targeted funding for free maternity care operated by the Ministry of Health)
LFA	Local Funds Agent
Litbangkes	Directorate of Research and Development (Ministry of Health)

M&E	monitoring and evaluation
MCH	maternal and child health
MDG	Millennium Development Goal
MNH	maternal and neonatal health
MoF	Ministry of Finance
MoH	Ministry of Health (Kementerian Kesehatan/Kemkes)
MONE	Ministry of National Education
mutasi	the continual turnover of staff at all levels of the health system
NGO	non-government organisation
NHA	national health accounts
NTT	Nusa Tenggara Timur (East Nusa Tenggara) Province
OECD	Organisation for Economic Co-operation and Development
PHA	provincial health account
PHO	provincial health office
PM	Program Manager
PMU	Program Management Unit
PNPM—Generasi	Program Nasional Pemberdayaan Masyarakat Generasi Sehat dan Cerdas (National Program for Community Empowerment—Healthy and Smart Generations)
Poltekkes	health polytechnics
Poned	Pelayanan Obstertri Neonatal Dasar (management of basic emergency obstetric neonatal care)
Poskesdes	maternal and child health post (at the village level)
PPJK	Centre for Health Financing and Social Health Insurance, Ministry of Health
PR	Principal Recipient
Prodi	nursing and midwifery study programs
PSC	Program Steering Committee
PTS	Program Technical Specialist
Pusdatin	Centre for Data and Information Management
PUSDIKLATNAKES	Pusat Pendidikan dan Latihan Tenaga Kesehatan (Center for Health Workforce Education and Training, Ministry of Health)
PUSLITBANGKES	Pusat Kajian dan Pengembangun Kebijakan Kesehatan (Center for Health Policy Development, Ministry of Health)
Puskesmas	Pusat Kesehatan Masyarakat (primary health care community health centre at the sub-district level)
Renstra	Rencana Strategis (strategic plan, Ministry of Health)
Risikesdas	primary health research
RPJMN	Rencana Pembangunan Jangka Menengah Nasional
SR	subrecipient
SSR	sub-subrecipient
Susenas	National Socioeconomic Survey (a survey conducted periodically by BPS in every province and district of Indonesia)
TA	technical assistance
TWG	AusAID – Global Fund HSS Technical Working Group
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund

USAID	United States Agency for International Development
WHO	World Health Organization
