Australia Indonesia Health Systems Strengthening Program Annexes

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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 system and health policy issues in Indonesia. It outlines the key challenges that exist and where the HSS program can contribute.

This assessment has the following sections:

1. Health status in Indonesia.
2. Health policy environment
3. Health financing and health system
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 with good progress on many key indicators, but worryingly slow progress on improving maternal health. The total population in 2010 was 237 million.[1] The fertility rate is declining and life expectancy at birth was 67 in 2010.[2]

MDG 4 – Improving Child Health: Indonesia has made good progress and is on track to achieve the MDG on reducing child mortality. Under 5 mortality has decreased from 97 to 44 per 1,000 between 1991 and 2007.[3] Infant and neonatal mortality are also declining and on track. Infant mortality has decreased from 68 to 34 per 1,000 live births (between 1991 and 2007) and neonatal mortality from 32 to 19 per 1,000 live births in the same time. [4] However immunisation coverage is low for a MIC low at 77% (Cambodia and Vietnam are both above 90%)[5] and stunting is high in children under 5 at 40% in 2000-2009.[6]

MDG 5 – Improving Maternal Health: Indonesia requires a considerable effort to reduce its maternal mortality rate. Progress has been slow and maternal mortality is

[1] 2010 Population Census, BPS, quoted in 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', BAPPENAS 2010.
[2] WHO, World Health Statistics 2010.
[3] BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.
[4] Ibid.
[5] The Lancet Series on South East Asia
[6] WHO, World Health Statistics 2010.

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particularly low (228 per 100,000 live births) in 2007.[7] This is far short of its MDG target of 102, much worse than Vietnam (64 per 100,000) and Philippines (with a similar GNI per capita) (84 compared per 100,000).[8] Skilled birth attendance increased considerably from 43 to 73% between 1992 and 2009.[9] Ante-natal care is increasing. Completion of 4 ANC visits is relatively high regionally (81.5% in 2007, compared to 74% in Thailand and 78% in the Philippines) but still not sufficient. There continues to be unmet need for family planning which requires further attention.[10]

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 TB MDG targets. HIV prevalence was 0.2% in 2009.[11] Condom use at last high risk sex is low (10.3% for women and 18.4% for men in 2007) and access to treatment remains low (38.4% of population with advanced HIV infection in 2009). TB case detection has increased considerably to 93% (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 NCDs was 690 per 100,000 in 2004, compared with 272 for communicable disease.[12] There are some high risk factors – smoking prevalence is very high amongst adult men (61.7% in 2006) and amongst male adolescents (41%).[13]

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 there are a few outstanding challenges.

2. Health policy environment.

2.1 Government Commitment to Health

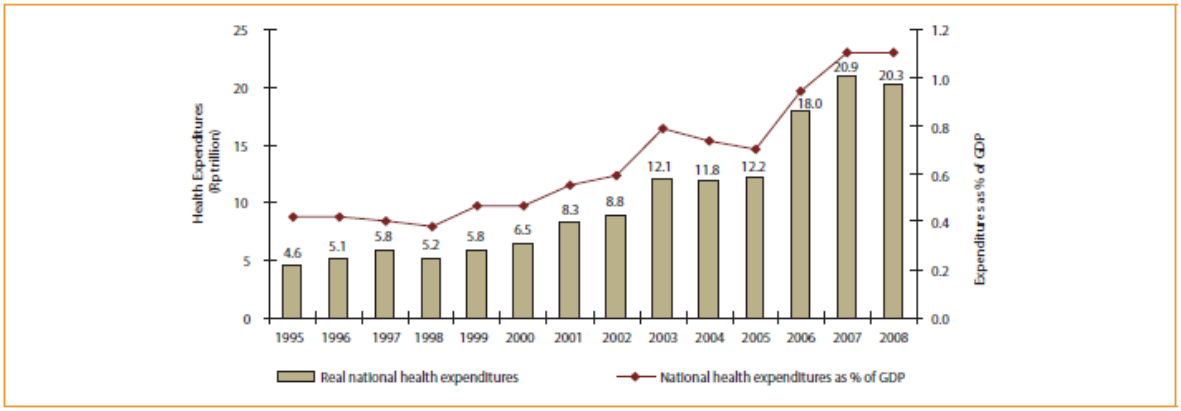
The Government of Indonesia is increasing public funding for health care and is committed to achieving universal coverage after years of under investment in the health system. Government commitment to meeting the health MDGs is articulated in the' A Roadmap to Accelerate Achievement of the MDGs in Indonesia'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

[7] BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.
[8] The Lancet Series on South East Asia
[9] BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.
[10] BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.
[11] Ibid
[12] WHO, World Health Statistics 2010
[13] WHO, World Health Statistics 2010

Increasing government commitment to health is demonstrated by the increasing public health expenditures (see figure 1).

Figure 1: Trend in public health expenditures, 1995-2007

Figure 3.2 Trend in public health expenditures, 1995-2007



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 (reform of the former Ashekan) to provide coverage for poor people, the BOK in 2010 to fund operating costs of primary health care centers 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 this has not yet been implemented but it appears that there is still commitment to achieving universal coverage and the key question is how. In 2009 the Health Law no. 36 made it a requirement for 5% of the national budget and 10% of district budgets to be allocated to health. The Ministry of Health 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.[14] They are constrained by multiple funding channels with different reporting requirements, a slow budget approval process which results in the first resource disbursement occurring often half way through the year, and by the centralised control over human worker regulations and placements. In many

[14] World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

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instances the government is not seeking assistance to make new or better policies, but to support implementation and refining of existing pro-poor policies.

2.2 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% in 2008, but in rural areas was 71 and 89 in urban areas. Improvement sanitation coverage was significantly lower at 52% overall, but only 36 % in rural areas.[15] The 'Roadmap' notes that 'Special attention is required to achieve the MDG targets for Goal 7 by 2015.'[16] Australian assistance to the water and sanitation sector aims to provide safe water to 970,000 people and basic sanitation to 860,000, Through the Australia – Indonesia Water Hibah program, Australian assistance is helping to operationalize and fund a successful pilot program involving output based financing with 35 local governments. Australia has provided $20 million funding to the pilot program to provide household water connections to 76,000 homes and reform the water sector.

Indonesia has also made good progress on addressing other key determinants for health, the overall literacy rates and female education. Indonesia is on track to achieve primary education enrolment rates and literary rates, as well as already met or 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 years old children are still not enrolled in junior secondary school because schools are too remote, 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 AUD500million Education Partnership, will support Indonesia to improve learning outcomes through school building; 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 these responsibilities. In this section we consider key health

[15] WHO, World Health Statistics 2010.
[16] BAPPENAS 'A Roadmap to Accelerate Achievement of the MDGs in Indonesia', 2010.

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systems issues including health financing, human resources, infrastructure and pharmaceuticals, and then conclude by returning to the issue of decentralisation.

3.1 Health financing

Total expenditure on health as a percentage of GDP has increased from 2 to 2.2% 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% in the same period, while private expenditure on health care decreased from 63.4 to 45.5% of total health expenditure.[17] General government expenditure on health as a percentage of total government expenditure is low compared to other comparable countries, but increased from 4.5% in 2000 to 6.2% in 2007 (less than the Philippines, 6.7% and Vietnam, 8.7%).[18] Government decentralisation has legislated that districts should allocate 10% of their budget for health but the evidence suggests that many, in particular poor, districts fail to reach this target. Overall health expenditure in Indonesia per capita is comparatively low at $81 compared with $130 for the Philippines (see table below).

Figure 2: Regional Comparison of Key Health Expenditure Data[19]

	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**

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

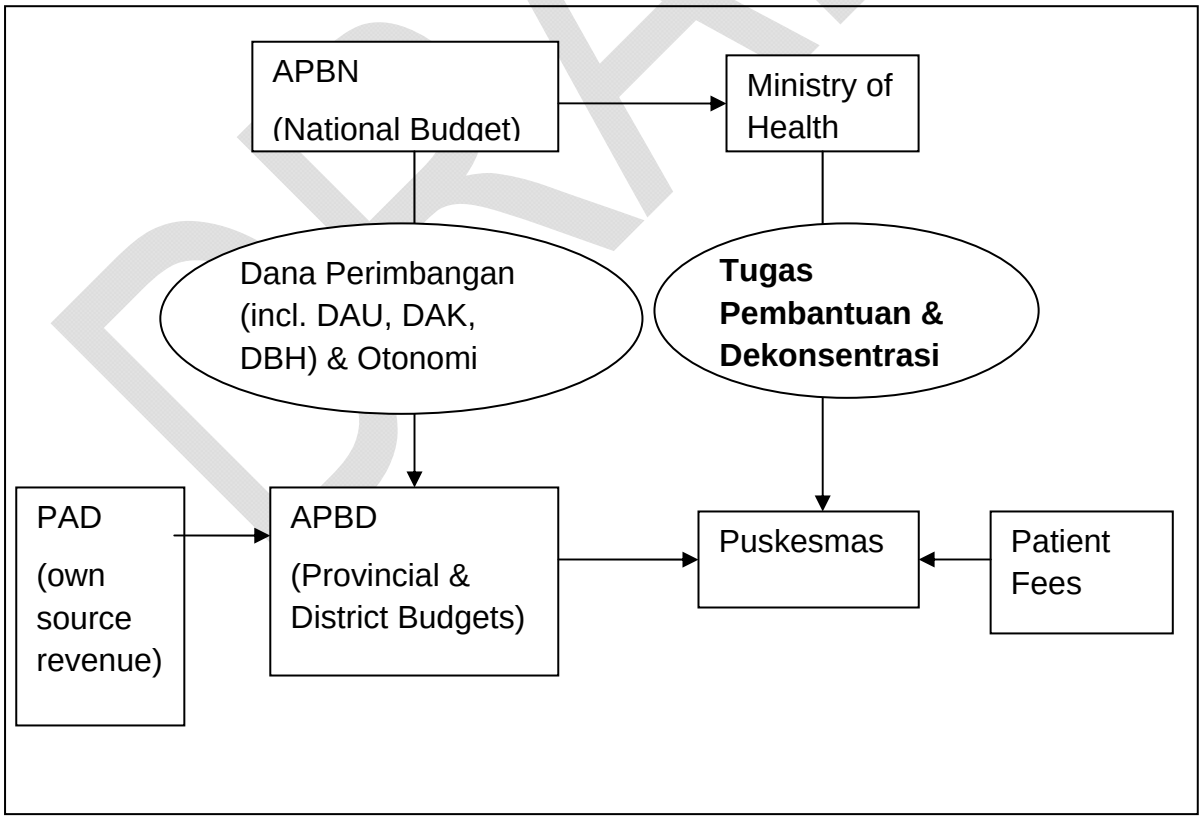
1. National to sub-national transfers through the APBN-APBD process.
2. Jamkesmas, public health insurance for poor people, administered at the Puskesmas level funds activities and is a subsidy to enable poor people to access free services.

[17] WHO, World Health Statistics 2010
[18] WHO, World Health Statistics 2010
[19] The Lancet South East Asia Series drawn from World Health Statistics 2010. Data is for 2007.

3. Bantuan Operasional Kesehatan (BOK), introduced in 2010, funds operational costs for puskesmas for preventative and health promotion.
4. Jampersal, introduced in 2011 to fund free maternal care and delivery for mothers in health facilities.

In 2008 42% of public health expenditure came from central government, 15% from provinces and 43% from districts.[20] These proportions were fairly constant since 2001 with an increase in the proportion from national government, a decrease from province, and a slight increase from district. Direct central government financing for health facilities through BOK and Jamkesmas is the largest source of funding for maternal and neonatal activities at the PHC level. Each of these funding streams has different administrative requirements. The complex annual planning and budget approval cycle, requiring hierarchy of parliamentary approvals from district level up to national level, results in a long delay in approval of plans and therefore for 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 to merge or streamline BOK, Jamkesmas and Jampersal to reduce transaction costs.

Figure 3: Simplified diagram of funds flows to Puskesmas



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

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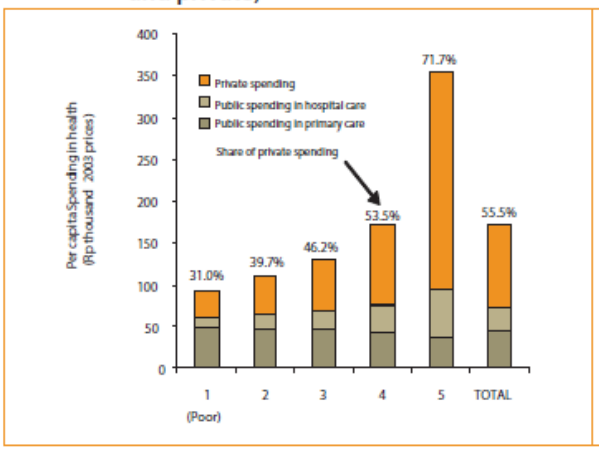
Source: AusAID working document

Health care financing is fragmented with slow disbursement. It is also not benefiting 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 rather than secondary care.[21] Data indicate that in 2008 the ratio of primary health care funding to hospital funding for the poor was 1:3.6.[22] Figure 4.1 shows the wealthiest quintile benefiting more from public funding for hospitals, and figure 4.2 shows poor people utilising primary health care more than hospitals.

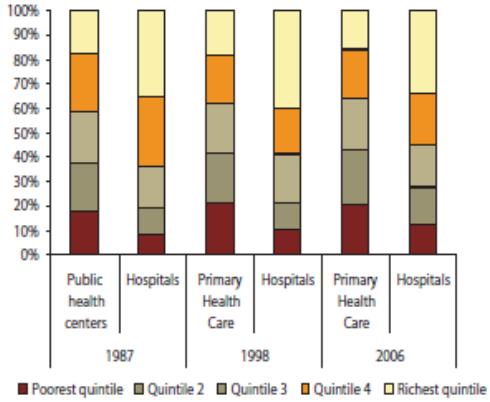
Figure 4.1 and 4.2

Figure 4.1 Benefit incidence of spending (public and private)



Source: World Bank staff calculations.

Figure 4.2 Healthcare utilization by quintile and type of care, 1987-2006



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

As noted above, private health expenditure is high and 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% in 2006.[23] In 2007, 66.2% of private health spending on health care was out of pocket, and private health expenditure was 45% of total health expenditure.[24] The World Bank estimates that in 2007 private health expenditure was 65% of total health expenditure and that OOP constituted 74% of private health expenditure.[25] This is higher than WHO estimate and implies that 48% of total health expenditure was OOP. This is a considerable financial barrier to care, or potential cause of

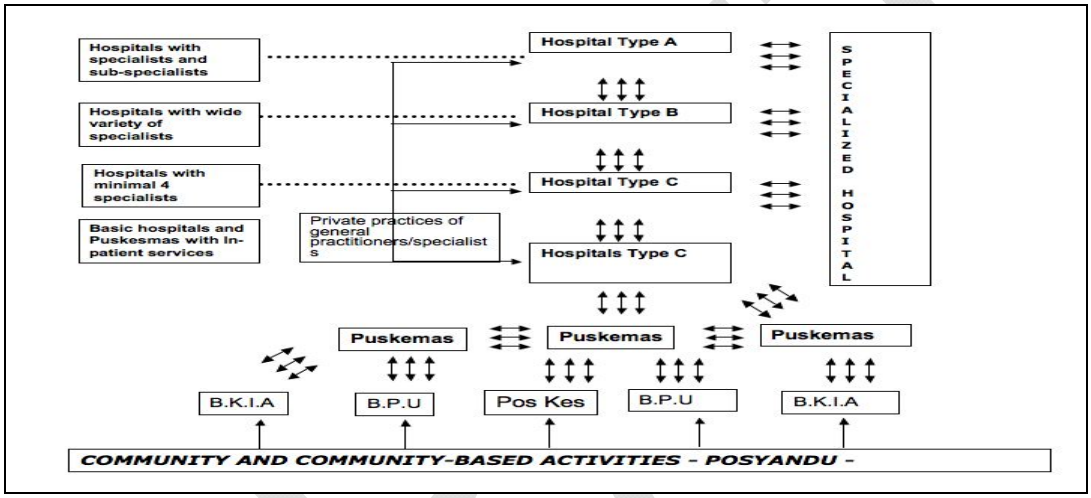
[21] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[22] Hasbullah Thabrany undated presentation non Indonesia's Health System.
[23] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[24] WHO, World Health Statistics, 2010.
[25] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008

impoverishment. Catastrophic health expenditure has been declining but still 0.9% of the population were impoverished as a result of health care costs in 2006, a substantial number of people given Indonesia's then population of 230 million.[26]

3.2 Health infrastructure

Indonesia has a mixed public and private health delivery system. The public health system expanded significantly in the 1970s and 1980s and by 2005 Indonesia had 7,700 Puskesmas with 22,000 health sub centres.[27] The private health sector has seen a significant expansion of private hospitals and private hospital beds, almost doubling between 1990 and 2005 to 626 hospitals and 52,300 beds, equalling the number of public sector beds.[28] The total number of beds per population is increasing but is still significantly lower than other south East Asian countries.

Figure 5: Indonesian Public Health Delivery System[29]



Puskesmas are the backbone of primary health care in Indonesia. There is considerable variation in the size of population served by the Puskesmas with an average of 100,000 people served by 3.5 Puskesmas.[30] However in most remote areas there are less than one Puskesmas per 100,000 populations.

3.3 Health Workforce

Health workforce per population in Indonesia is lower than other south East Asian countries as can be seen from the attached table.[31]

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[26] Ibid.
[27] Ibid.
[28] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[29] Presentation by Mulya Asmi, Direktur Bina Pelayanan Medik Spesialistik, Dirjen Yanmed on the Annual Social Obgyn Convention, Malang, 4 April 2008
[30] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[31] Ibid.

Figure 6: International comparison of health sector workforce

Table 2.2 International comparison of health sector workforce

	Physicians			Nurses			Midwives		
Country	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 absolute lack of health workers is particular severe at primary health care level in poor, rural and remote areas. The government has increased considerably the supply of health workers and public and private medical schools have increased. By 2008 there were 465 midwifery schools and 682 nursing schools producing 10,000 midwives and 34,000 nurses each year.[32] Increasing numbers of doctors is also a response to increasing private practice opportunities.

Puskesmas are understaffed with insufficient doctors, and many remote rural areas do not have sufficient midwives. There is also a serious question of dual practice with as many as 65% of public employed health staff having second jobs.[33] Absenteeism is very high at 40% in primary health care centres, and high compared to other south East Asian countries.[34] Evidence from two districts suggest that a village midwife earned as much as 58% of their income from private clinical work, and only 35% from publically funded clinical work.

The overall quality of the education health workers receive is low. The World Bank analysed data from Indonesia Family Lifestyle Survey (IFLS) as proxy for quality of health care provision and health workers.[35] 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 health worker ability to correctly diagnose and treat key child and maternal health presentations. The quality of health professional education, in particular for midwives and nurses, is also insufficient.[36] The government has recognised this and begun to implement measures by introducing new accreditation standards for medical schools and requiring medical schools to meet new improved accreditation standards.

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[32] World Bank, New Insights into the Provision of Health Services in Indonesia: A Health Workforce Study, 2010.
[33] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[34] Ibid.
[35] World Bank, New Insights into the Provision of Health Services in Indonesia: A Health Workforce Study, 2010.
[36] Ibid.

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There are issues in the organisation and utilisation of health workers which work against optimising efficiency. There are strict national controls on appointing health workers because they are civil servants which limit the flexibility for districts to innovate and find local solutions to their shortage or misdistribution of health workers. Central government still controls all permanent and temporary civil servants, 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.

3.4 Pharmaceuticals[37]

According to a recent World Bank study Indonesia has a 'strong foundation for effective regulation of the safety and quality of medicines.' Indonesia manufacturing meets most of the country's needs for medicines. Approximately 30% 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 as the largest proportion of medicines sold are branded generics, at higher than the international reference prices that could be paid. 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 MOH. There are inefficiencies in public procurement and supply chain management, exacerbated by the planning and procurement processes, overlaid with decentralised responsibilities for some aspects.

There is little clear evidence and analysis of corruption in the health sector. The possibilities that exist include; (i) incentives for large procurement contracts including infrastructure, equipment and medical supplies, (ii) allocation of sought after and limited health positions, in particular as full civil servants and (iii) accounting for health expenditure, in particular during the 'end of year rush' to realise health budgets. Corruption is an ever-present problem. Corruption not only makes the problem worse, but some policies have encouraged corruption, too, as has the lack of health resources. Closely related to the perpetual problem of corruption is the increasing commercialisation of electoral and money 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 as the provision of primary health care for the poor. The stark reality is that 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.

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

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3.5 Decentralisation and health care financing and management

National government transferred responsibility for managing and delivering health services to the population 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 these new responsibilities, and often constrained by national regulations, for example on civil service. AusAID is supporting the AIPD program 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 which limit the flexibility for district governments to re-allocate resources.[38] Local governments receive funding from multiple national sources including the DAU, DAK, sectoral allocations including Jamkesmas, Jampersal and BOK, and locally-raised revenue (PAD). DAK and DAU funding is heavily tied to specific expenditures (e.g. DAU for salaries). District governments lack the capacity to effectively manage these complex sources of funding for health. In 2006 only 73% of the money allocated to health was spent.[39] There are similar complexities in managing the health workforce, and with procuring and managing pharmaceuticals. The repercussions of a decentralisation process are still impacting on the ability of districts to deliver quality health care in an efficient way.

4. Health insurance coverage

The government is committed to achieving universal coverage of health insurance. In 2005 health insurance coverage was an estimate 85.9 million people, approximately 41% of the population (this assumed full coverage of the poor through Jamkesmas – which was not the case).[40] Almost 60% of the population therefore does not have health insurance and is at risk of 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. There are a number of factors. Many poor people who are entitled to free care under the Jamkesmas scheme are not currently participating.[41] Approximately 50% of health spending in 2009 was through out of pocket payments.[42] For the large number of poor or near poor this is a substantial risk to the catastrophic cost of

[38] World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008
[39] Ibid.
[40] Ibid.
[41] World Bank, Indonesia Health Sector Review: Does Jamkesmas Protect the Population from Health Expenditure Shocks? 2011
[42] National Health Accounts

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health care. In 2006 1.2% of households suffered catastrophic health expenditure (a reduction from 1.5% in 2005).[43] Impoverishment as a result of health care costs also decreased slightly from 1.2% to 0.9% 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%), and increases the likelihood of those covered to use in-patient services.[44] Jamkesmas beneficiaries are also 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 is a problem in many remote parts and smaller islands in Indonesia. Many of the interventions required to improve child and maternal health require effective primary health care for immunisation, ante-natal care leading to safe delivery and for 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 needed skills, or do not see 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 (doctors, nurses or midwives).

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

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

- Maternal health status is 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
- Government of Indonesia is committed to achieving the health MDGs

[43] World Bank: Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[44] World Bank, Indonesia Health Sector Review: Does Jamkesmas Protect the Population from Health Expenditure Shocks? 2011

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- Government of Indonesia has put in place policies to achieve universal coverage and in particular to cover the poor and improve maternal health
- 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 programmes 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
- Health financing is fragmented, overly focused on hospital care, and disproportionately benefitting 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 % of total expenditure on health (2007).[45] The Global Fund to fight AIDS, TB and Malaria is the biggest donor for health in Indonesia – with total commitment of $441.5 million ($132.5 million for HIV/AIDS, $173.6 million for TB and $135.4 million for Malaria). The Global Fund has recently approved a new Health Systems Strengthening program of up to US$35 m over 5 years which will focus support on improving health information systems and on strengthening pharmaceutical supply chain and management. The World Bank and Asian Development bank look to be coming to the end of their support for health systems development as Indonesia, now a middle income country, is no longer eligible for IDA loans. The World Bank currently has a loan with Ministry of Education to improve the training of health workers, and the ADB has a decentralised health services program that will shortly be ending. World Bank continues to play a useful role in developing high quality analysis of health systems constraints and challenges, in particular in health financing. USAID is active in supporting a program in subsectors that largely reflect AusAID's health sector investments in HIV/AIDS, maternal and child health and communicable diseases (malaria, EID, neglected tropical diseases). Because US and Australia are the two largest bilateral donors to health, a partnership is developing with the aim of strengthening policy dialogue with Government, ensuring complementary program investments in subsectors and sharing of lessons learnt. DFID is now closing its support for maternal health in conjunction with the World Bank. GTZ 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 we have supported their operational activities performance has been less than optimal. In particular, our work through UNICEF on maternal and child health did not

[45] WHO, World Health Statistics, 2010

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deliver on outcomes expected. This may be related to their relative in ability to work closely with GoI systems and difficulty in retaining staff particularly in remote areas.

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Annex 2: Poverty and social analysis

Introduction

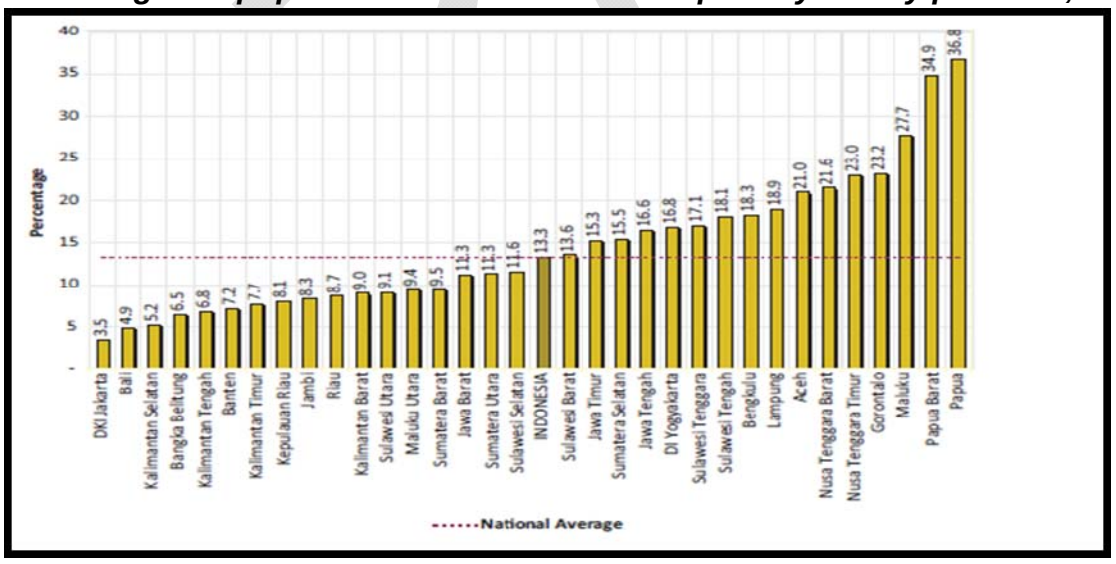
This annex summarises the social and poverty analysis and appraisal for the Indonesia Australia Health Systems Strengthening program. This analysis addresses the following issues:

1. Poverty in Indonesia
2. Health status of the poor and vulnerable
3. Barriers to the poor and vulnerable accessing health care
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. 5.9% of Indonesia's population were living on less than $1 per day in 2008.[46] In 2010 13.3% of the population lived below the national poverty line, equal to 31 million people.[47] This represents a considerable number of poor people. In addition to the number of poor people there is a very large number of Indonesians who live just above the poverty line, living on less than $2 per day, and extremely vulnerable to poverty. In 2006 there were 49% of the population living on less than $2 per day, representing 108 million people, and the World Bank suggests that 'there is little that distinguishes the poor from the near-poor.'[48]

Percentages of population below the national poverty line by province, 2010



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

[46] BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010
[47] BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010
[48] World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

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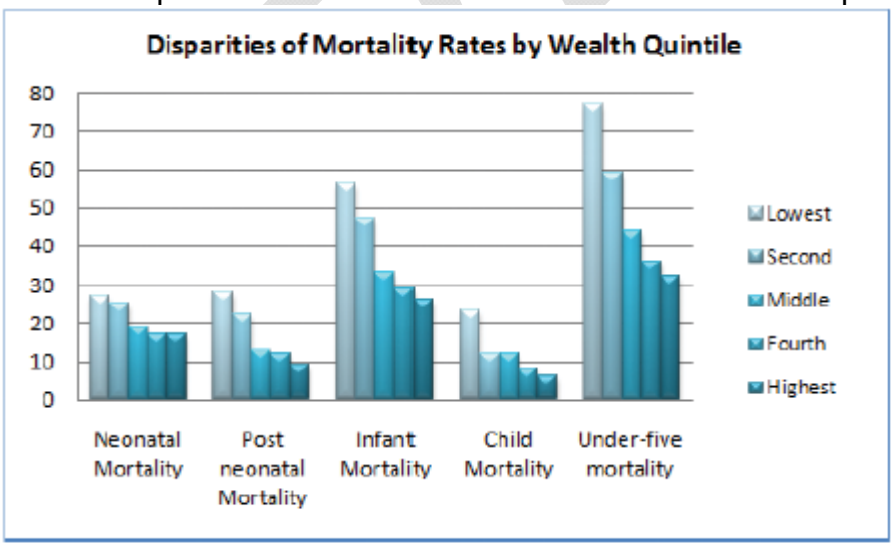
In such a large and geographically diverse and remote country with thousands of islands it is not surprising that there are serious disparities in income and poverty incidence between different provinces, as demonstrated in the table below. In addition poverty is higher in rural areas, 16.56% in 2010 compared with 9.87% in urban areas.[49] 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: namely that income poverty does not fully capture poverty because many people could be considered poor because of their lack of access to basic services and fundamental human development outcomes.[50]

The non-income elements of poverty in Indonesia include lack of adequate consumption, education, health and access to basic infrastructure like water and sanitation. In Indonesia malnutrition rates are high, and maternal health has declined but remains excessively high for a middle income country. This suggests that improving access to basic primary health services will make a contribution to improving the livelihood of the poor and vulnerable in Indonesia.

2. Health status of the poor and vulnerable.

There appear to be few studies published that analyse the health status and health care utilisation of the poor and near poor in Indonesia. This would be a worthwhile early investment for the HSS program. However there is evidence on health inequalities in Indonesia which suggests that income quintile, place of residence and education level of mother are strongly associated with health status. The table below shows how child health outcomes are worse amongst the poorest and most vulnerable quintiles. WHO data from 2007 shows the same picture.[51]

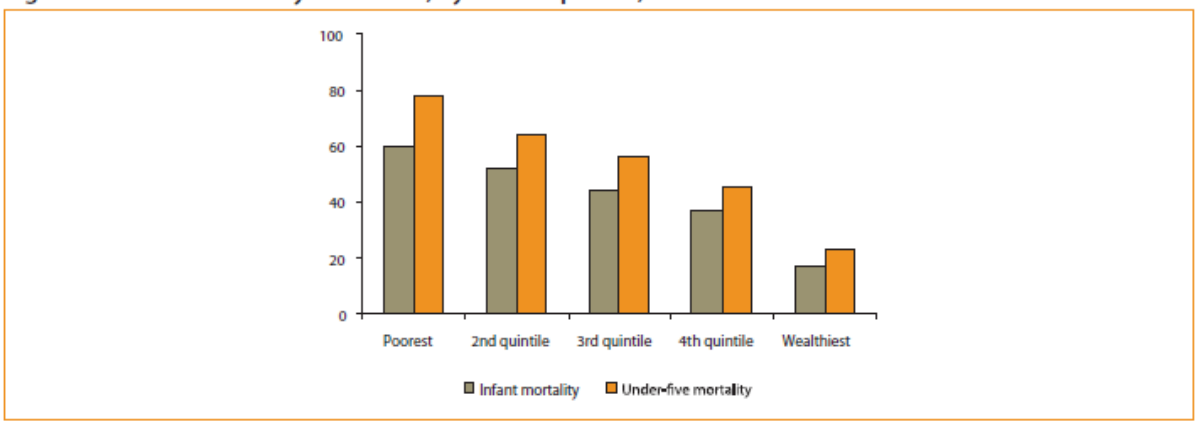


Source: BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010

[49] BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010
[50] World Bank, Making the New Indonesia Work for the Poor (Overview), 2006
[51] WHO, World Health Statistics, 2010.

There are also similar income quintile inequities for infant mortality and under 5 mortality rates as evidenced in the table below from the World Bank Public Health Expenditure Review.

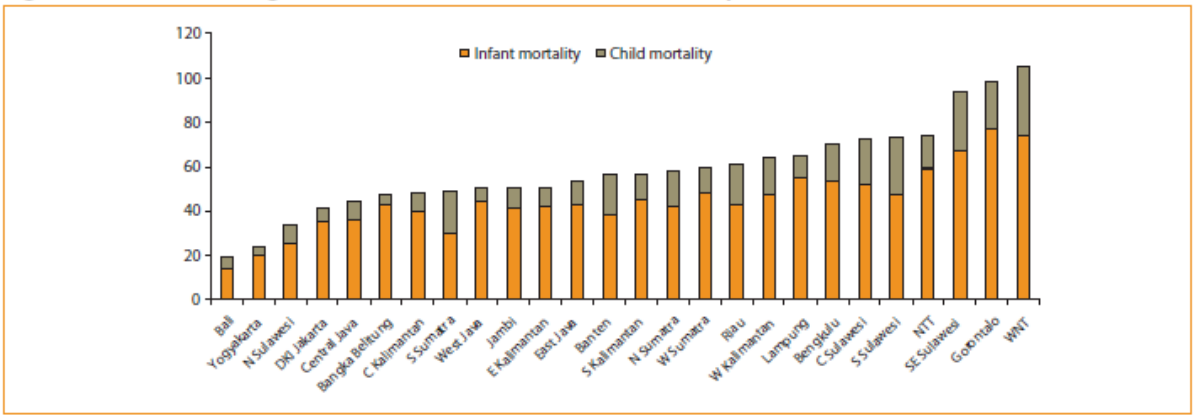
Figure 1.4 Infant mortality and U5MR, by wealth quintile, 2002-03



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

There are also geographic disparities in infant and under 5 mortality rates as evidenced in the table below.

Figure 1.2 There are large differences in IMR and U5MR between provinces



Source: IDHS, 2002-03.

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

Poor people are accessing less critical health care for maternal and child health than wealthier people as can be seen for skilled birth attendance and measles immunisation coverage in the table below.

Coverage of key services in 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 deliveries in facilities is higher in urban areas (70.3%) than in rural areas (28.9%) and urban women are more likely to receive some antenatal care than rural women.[52] There are also considerable provincial disparities in the proportion of women receiving antenatal care and delivering in facilities.

3. Access to health care by the poor and vulnerable

There is considerable evidence which demonstrates that poor and vulnerable people access less health care than wealthier. The barriers to accessing health care include geographic remoteness, cost, not knowing their entitlements under public health funding schemes, not knowing where to go, transport, and for women also not obtaining permission or concern about not finding a female provider available. This mixture of reasons, combined with wealth quintile, is captured in the below table extracted from the 2007 Demographic Health Survey. This tables shows that for women the cost, distance from health facilities and the need to take transport are very significant barriers to women accessing health care.

Problems in accessing health care: % of ever married women reporting big problems accessing health care

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 data published 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. Where do the poor people go for their health care? The table below from the World Bank suggest that the poorest two quintiles utilise significantly more primary health care then they do hospital care, the inverse of the wealthiest quintiles.[53]

[52] BAPPENAS, A Roadmap to Accelerate Achievement of the MDGs in Indonesia, 2010
[53] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

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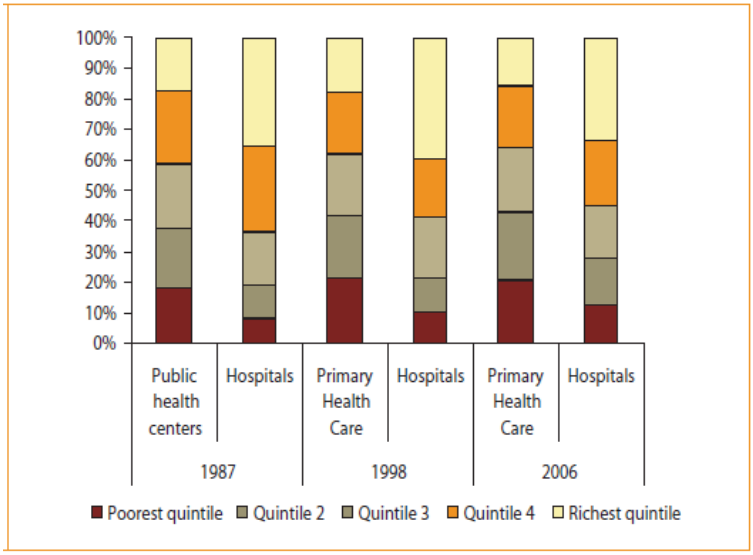
Figure 4.2 Healthcare utilization by quintile and type of care, 1987-2006



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

Out of pocket expenditures for health care in Indonesia have 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% in 2006.[54] In 2007, 66.2% of private health spending on health care was out of pocket, and private health expenditure was 45% of total health expenditure.[55] This means that a considerable proportion of health spending is made out of pocket – a considerable financial barrier to care, or potential cause of impoverishment. Catastrophic health expenditure has been declining but still 0.9% of the population were impoverished as a result of health care costs in 2006, a substantial number of people given Indonesia's then population of 230 million.[56]

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

4.1 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 a comprehensive, equal, quality and fair health efforts.

[54] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[55] WHO, World Health Statistics, 2010.
[56] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.

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3. To ensure the availability and equal distribution of health resources.
4. To create good governance.'

Mission 2 and 3 both refer to equity in terms of distribution and availability of health services and health resources. The strategic plan also includes a value statement that reinforces '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' both include prominently 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 however little data in government documents on poverty, equity and health.

The World Bank identified making services like health work better for the poor as one of three priority ways to fight poverty in Indonesia.[57] In particular the World Bank highlights the need for better primary health care, which in turn requires better incentives for the poor people, and for providers. This involves reducing the financing barriers discussed above, and 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 HSS program:

- '3. Invest in health with a focus of 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.'[58]

The Government's health strategy does not outline a clear analysis of health status by income quintile or a clear analysis 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 AIHSS program to support the generation and analysis of evidence on the interaction between poverty, equity and health (care) in Indonesia.

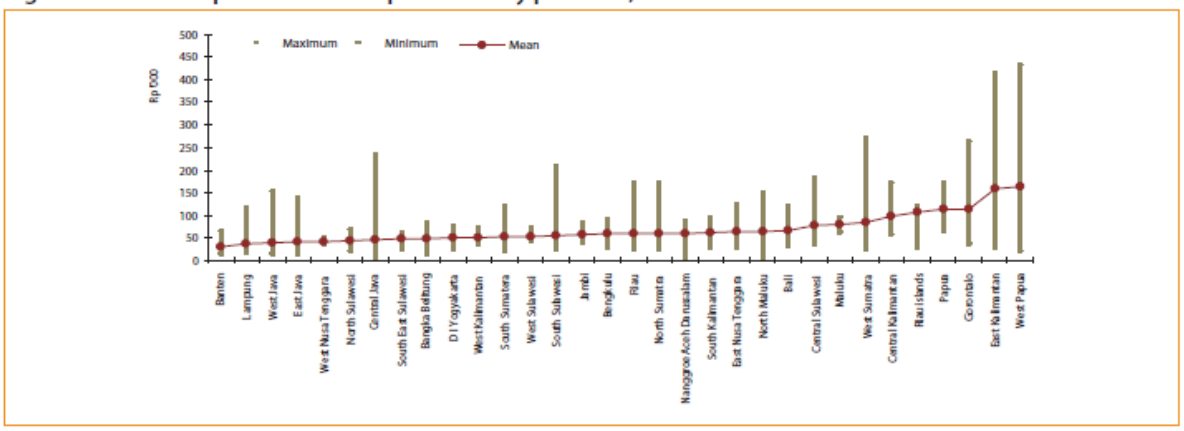
4.2 Allocation of health resources

According to the World Bank 'the level of health expenditure varies considerably between regions in Indonesia' and 'district public expenditures for health are, as

[57] World Bank, Making the New Indonesia Work for the Poor (Overview), 2006
[58] World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

expected, higher for districts with larger budgets and higher per capita incomes.'[59] See figure 4.3 from World Bank.

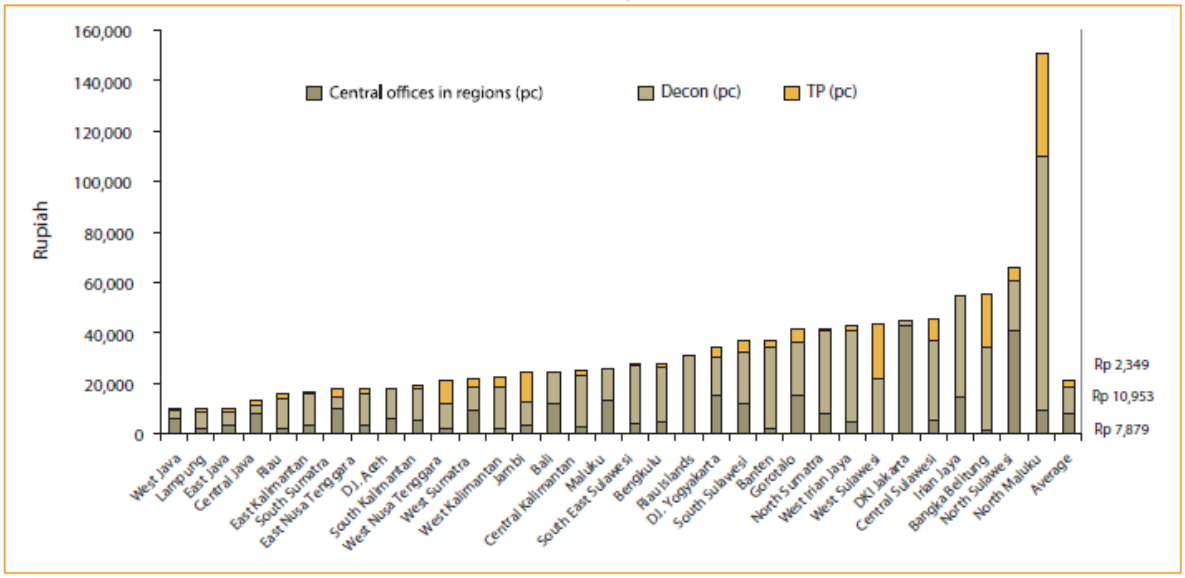
Figure 4.3 District public health expenditure by province, 2005[60]



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

According to the same World Bank analysis the central government expenditure per capita to the eastern regions 'is more than double that of the west.'

Figure 4.4 Central government health sector spending by province, 2006[61]



Source: MoH, Bureau of Planning, 2007.

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% of the MoH budget was spent in 2006[60], and report that in any year expenditure starts slowly and accelerates towards the end of the year. This is due to the slow planning and budgeting process which requires draft budgets to go through many rounds of negotiations at district, province and national level before final approval.

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[59] World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, 2008.
[60] Ibid.

Annex 3: Economic Analysis for AusAID Indonesia HSS program

Introduction

This annex summarises the economic financial analysis for the Indonesia Australia Health Systems Strengthening program (AIHSS). 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 case for investing in health systems strengthening - cost to the country of ill health and inefficiencies in health system
2. Financial analysis of the AIHSS to the health sector and issues of sustainability
3. Fiscal impact - how additional costs can be financed

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

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 utilises international evidence on cost-effectiveness.

AIHSS has both a general and specific focus. The general focus is on strengthening of 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 since provision of basic and comprehensive 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). AIHSS therefore gives specific emphasis on improving maternal and neonatal health service provision in order to directly address maternal health indicators that have persistently fallen short of national and international targets (MNH).

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

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countries and even in low income countries such as Sri Lanka that have placed an emphasis on improved system access is evidence that much 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, such as nutrition related illness, has 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 in order 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 MMR since the late 1990s, the levels 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[61].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 emergency life-saving care, requiring 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 in reaching facilities that are properly equipped with requisite skills is seen as a major impediment 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, these 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, that more than 55% of maternal deaths and 22% 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 AIHSS 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% of the population benefit from 65% of the spending on maternal care at hospital level (Quayyum, Ensor et al. 2007). At the same time earlier World Bank analyses found that the top 20% of the population in

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

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Indonesia accounted for only 7% of infant deaths while the bottom 20% accounted for 36 percent[62]. Geographic inequalities are also apparent. Birth with a skilled assistant ranges from more than 98% in rich Jakarta down to less than 43% in the poor, remote province of Maluku (BAPPENAS 2010). The village midwife programme has increased numbers of skilled birth attendants across Indonesia but coverage remains uneven. In addition midwife dependence on private income (largely unregulated) means that 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.

AIHSS focuses on critical health system weaknesses including:

- Improving needs based planning and budgeting
- the affordability of health care by improving the targeting of services
- increasing the supply of well trained staff through a focus on improved accreditation of nursing and midwifery training
- increasing the availability of services through an improvement in local level planning manifested in an improvement in cash flow, staff retention and stocks of essential medical items.

These foci have potential to improve the capability of puskesmas and network to deliver services that are effective at reducing the need for patients to bypass these facilities and go directly to hospitals. In addition improvements in training should improve the recognition of signs for referral which are supported by investments in targeted transport to ensure patients are rapidly transferred to hospital where required.

Three justifications for the planned inputs can be identified.

- **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 falling more slowly than other countries in the regional, it is lower than expected compared both to per capita income and amount spent on health care. The main exception here 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

[62] 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.

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World Bank suggests that improvements in outcomes expected from additional spending is dependent on a country's institutional and organisational capability (as measured by the Country Policy and Institutional Assessments (CPIA) Index) (Gottret and Schieber 2006). The analysis suggests that for Indonesia, with a relatively high CPIA, that the gains in maternal outcomes from additional spending are significant (a 10% increase in budget leading to a 7% reduction in the MMR). This is a major reason for the specific emphasis on MNH in AIHSS.

- **Focus on cost-effective services** The interventions that are proposed for AIHSS largely effect services that are of proven cost effectiveness. At district and provincial level, to which much of the budget is targeted, the focus is on improving functionality of facilities at Puskesmas 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 childhood diseases such as TB, Malaria, HIV/AIDS and maternal health for which there are well known, cost-effective preventive and curative services. These services can mostly be treated 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 onward referral to hospital. Training for health centre staff will propose including the observation of danger signs and management of emergencies to ensure this vital referral function.

- **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 (see page 71, (Rokx, Schieber et al. 2009)). A number of these weaknesses will be addressed through AIHSS including:
    - Non-compliance with good practice protocols
    - Relatively low levels of skilled human resource
    - Uneven deployment, low motivation of health workforce and dual working practice
    - Lack of needs-based planning

  These weaknesses are currently seen to impede the provision of high quality services in the private sector leading to self-treatment and no-treatment and also self-referral to hospital. AIHSS focuses on improving the planning and budgeting of services and improving skills of staff. Studies will focus on the problems of human resource retention and motivation.

Health system strengthening envisaged in AIHSS are 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. This will be mitigated by increased

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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 outputs 3 at 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/attendant. More rapid treatment usually reduces the period sickness and time required away from productive activities. For specific conditions, notably tuberculosis, effective care can only be provided close to communities because of the requirement to make frequent follow up visits to receive treatment, Furthermore it also usually easier for communities to distinguish and give priority to the poorest people in the communities.

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, The intention is to understand the implications for public budgets of the on-going resource commitments implied by the program.

A useful distinction for purposes of analysis is to divide expenditures into (Table 1):

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

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 without any detrimental impact on the continued operation of the services supported by the programme. These could include costs of programme 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. In order to sustain the results of the program, these on-going 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 programmes. Much training can be placed in this category since staff may be provided with initial training during the programme periodic investment is required beyond the programme through refresher training for current staff and to train new staff. Equipment is a second area where periodic investment is required. In many

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programs, particularly those of development banks, equipment represents one of the main parts of program spending and also generates the largest on-going recurring cost burden to the sector. Small well used equipment (e.g. Sphygmomanometer, stethoscope, computers) require replacement every 3 or 4 years and larger equipment (e.g. vehicles, autoclave) very 8 or 10 years.

The final category are 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 programmes 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 1: Program financial impact, types of costs and savings

Cost	Generic examples
One off or program related administration	Program management training International TA 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 (programme specific)

The total budget for the proposed program is $49.4 million. Whilst 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 (Table 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 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 in order 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.

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

- Substantial training across outputs but particularly on the development of new systems of budget and planning at national and local level (Output 1 & 2), training for facility staff (Output 3) and training of trainers (Output 4). This knowledge will require update and transfer 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 since many of the skills imparted are also desirable in other sectors or private health sub-sector. Retaining and motivating skilled staff is already a major problem in the sector. The problem becomes even more acute as staff skills are improved.

Table 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 HR information system; TA to policy unit	Training for staff to run new HR systems	Incentives to retain staff	
Output 2 & 3	29.90	60.5%	TA on planning & 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%	TA 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%	TA on health policy network		Staff to maintain network and research of network	
M& E	2.80	5.7%	Program M&E		On-going M&E costs required to ensure high quality programme results.	
Other	8.32	16.8%	Management and TA 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 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 ARIs which could be prevented or treated within the community and sub-district level facility network.

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Without a detailed knowledge of item-wise 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 TA and training mean that the overall recurring financial burden is substantially less than for a similar spending program dominated by equipment procurement. The on-going training and staff incentive costs would, however, will need to be assessed during the program to ensure 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 provided with the capabilities developed 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*.

Fiscal impact analysis

Fiscal impact analysis focuses on the way in which additional costs imposed by a program can be financed to ensure 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 national, provincial or district level. This is similar to the process being undertaken on the AIPMNH program which plans to increase cost-sharing and sustainability in the next 2 years.

It appears that AIHSS 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% 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 of AIHSS spending 61%, will be spent at provincial and district level. It is envisaged, for example that in districts, $100,000 will be spent in districts in the first year rising to $300,000 in subsequent years. At province level it is assumed that spending will be start at $600,000 in the first year and rise subsequently to $900,000. This implies that AIHSS spending would represent around 7% of average district and 4% of average provincial annual budgets. The PER suggests, however, that around 80% of spending at district level (64% in provinces) is on staffing. Assuming this expenditure is largely immutable, additional costs arising from the program will need to be absorbed by the non-staffing budget. Even if we assume that only a third of costs need to be financed on an annual basis to ensure the services are preserved, this still suggests that funding amounting to around 12 percent 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 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%

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in 2099 down from 6.3% 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% 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 implying an additional resource envelope that could accommodate the additional costs. In 2006 5.3% of the total government budget was allocated to health. Countries in the region spend 10% on health while internationally many low and middle income African countries have committed in the Abuja Declaration to commit 15% of the total government to health care. The proportion of the government budget devoted to health would only need to rise to 6.5% 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 AIHSS provided that a good case can be made to the Ministry of Health and District administrations that the investment has had impact. In the recent past the Government has shown itself ready to spend on programmes to are seen to have substantial impact such as the insurance for the poor (originally Askeskin now Jamkesmas) financed out of the reduction in fuel subsidy. This reinforces the need for a robust monitoring and evaluation framework.

A further important source of financing of costs are the insurance funds – both public and private - which 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 these costs. One of the ways to do this is to improve the primary care network in order 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 AIHSS programme is a complex programme, attempting to strengthen aspects of the health system that have potential for substantial benefit. Financial costs beyond the programme are important but appear manageable. There are, however two more fundamental issues relating to programme implementation. The first relates to generally low level of funding for the health sector and public commitment to the health system. Interventions prioritised by the programme 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 great 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% in total of which 1% is public (World Bank 2008). Regionally total spending is closer to 4%. Part of the issue of low funding is associated with under-spending on the budgets allocated. The

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national Ministry of Finance or local government are unlikely to provide more funding while existing budgets go untouched. The Health PER, for example, documents under-spending on local health budgets of 27% (only 73% of budgets were used) (World Bank 2008). Several activities in AIHSS, in particular output 2, are focused on helping local governments to improve planning and budget capabilities. If successful, this should have a positive impact on absorptive capacity and provide strong evidence in advocating for an increase in government spending.

A second issue relates to the way in which interventions are implemented rather than in the details of item-wise spending. The program is primarily about capacity and capability development. Transferring this 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 required completely fresh investment in capacity. The precise details of how this 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 AIHSS 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 both of the maternal mortality data, as well as 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 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 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 HSS program in Indonesia. It includes some gender (in)-equality elements, as far as the very limited data permits. It outlines the key potential opportunities for the HSS 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 (GASHI) for the design of the program, and the gender strategy of the existing AIPMNH program. It does not constitute or replace a detailed gender plan or strategy for the HSS program, which should be part of the first annual work plan for the national Program Management Office (PMO). An early detailed gender appraisal should cover an assessment of the core issues highlighted. Whilst this Annex suggests some initial points of focus, gender equality will be integral across all HSS activities from implementation to monitoring of outcomes.

This assessment has the follow sections:

6. Research, evidence and knowledge management.
7. Health status and access to primary health care of women
8. Gender and health
9. Gender, health policies, health systems planning and health systems strengthening.
10. Partners for advancing gender equality in decentralised health services: national, provincial and district.
11. Targets, objectives, monitoring, evaluation and gender in the design and logframe.
12. Gender, participation and accountability.

1. Research, evidence and knowledge management

In order to address the issues and challenges of gender inequality in terms of access to health care, detailed and current empirical evidence and statistical research is a vital first step. The GASHI gender assessment, conducted in June 2010, highlighted the issue of a lack of gender specific data on women utilising health care and primary health care services. It would be useful to be able to disaggregate the statistics on health status and health service utilisation by sex (and ideally age) when gathering information for program baselines. This would help inform assessment of impact and outcomes by activity on both men and women (and where possible be broken to include data on boys and girls). There is very little information in the public domain on gender disaggregated mortality, morbidity or health risk factors. Data on women's health needs across their lifecycle would also be essential for planning

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health services. Data collection will also need to be mindful of Indonesia's ageing population, predicted to reach 11.37% of the population by 2020.[63]

The lack of detailed and comprehensive population data, including consistent civic registration, birth certificate, marriage/divorce's 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[64] 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 (GASHI, 2010). Studies indicated that people obtain a birth certificate when they needed it for school enrolment.[65] This registration system needs greater enforcement in order to identify trends in populations, gender differences and future health needs across the country.

2. Health status and access to primary health care of women

Maternal Health

Maternal health is one of the country's top priorities for the GoI and MoH. The current Maternal Mortality Ratio (MMR) for Indonesia is 228 maternal deaths per 100,000 live births – among the highest in East Asia[66]. Despite the existing programs and interventions the rate of reduction of maternal mortality has been slow, and the government recognizes it will be a challenge to achieve its stated Millennium Development Goal of 102 maternal deaths per 100,000 live births by 2015.[67]

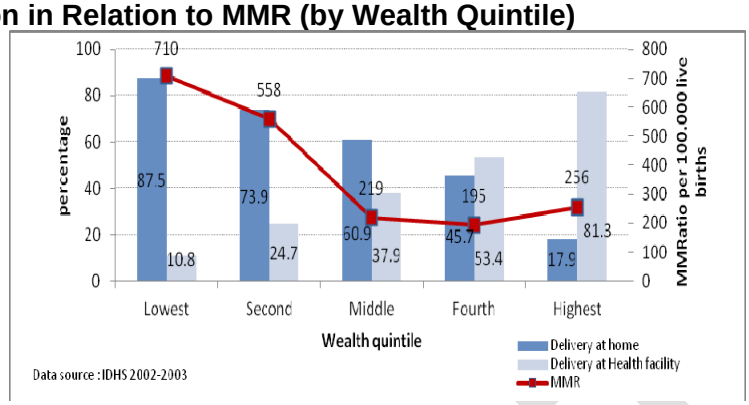
There are a number of possible contributory factors. Standards of working practice by skilled birth attendants are not universal and training is not always adequate for when complications arise. The MoH needs to implement universal accreditation standards for midwifery and nursing training generally. 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, with more than half trained obstetricians practicing on the island of Java. There is also a distinct urban: rural bias in maternal health care provision.

The Indonesia Making Pregnancy Safer strategy emphasized the importance of skilled birth assistance. Policies to support the strategy (i.e. 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 percent in 1987, to 73 percent 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 professional, compared to only 10 per cent of the poorest quintile in two Serang and Pandeglang districts in West Java.[68] This 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

[63] US Census Bureau International Database (2009)
[64] UNICEF, Gender and Poverty Study, 2008
[65] UNICEF, Gender and Poverty Study, 2008
[66] Lancet, 2010
[67] World Bank "...and then she died." Indonesia Maternal Health Assessment February 2010
[68] World Bank Indonesia Maternal Health Assessment February 2010

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 the diagram below.

Delivery Location in Relation to MMR (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 contribute to continuing utilization of abortion services. It is estimated that one to two million abortions take place in Indonesia each year, with many performed by unskilled providers in unsanitary conditions[69].

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 under nutrition with disparities across the provinces. A 2009[70] study has suggested that 20 per cent of early neonatal deaths could be attributed to a lack of iron and folic acid supplementation during pregnancy. Poor infant and child feeding practices are also impacting on child health. The disparity of the nutrition status is quite wide among the regions and socio-economic levels. 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 until the age of 2, with considerations to the impact of physical growth, intelligence, and the productivity of future generations (WB, 2006).

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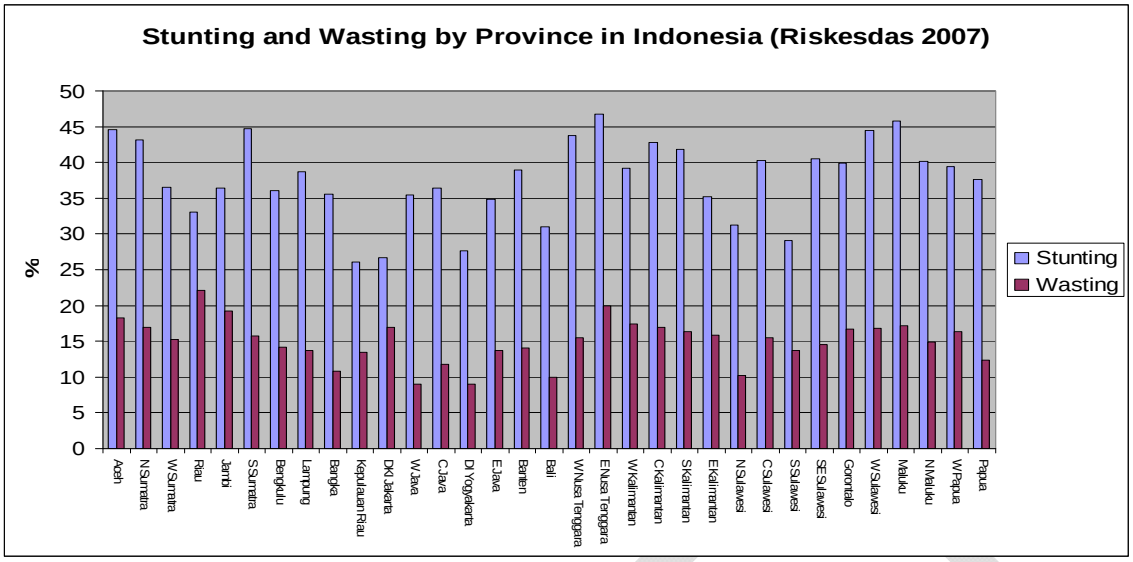
[69] Hull et al 2009
[70] Titaley C.R., M.J. Dibley, C.L. Roberts, J. Hall and K. Aghod. 2009. Iron and folic acid supplements and reduced early neonatal deaths in Indonesia. Bull World Health Organ 87: 1–23.

Stunting and Wasting of Children Under five by Province (*Riskesdas* 2007)



Behaviour Change Communication (BCC) would help to empower mothers to improve the nutritional status of their children. This 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 BCC 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 over-looked in terms of child survival. Improving the understanding of child health and nutrition among fathers and community decision makers is often equally important in ensuring children receive appropriate preventive and curative health care.[71]

The proportion of children age 12-23 months who were fully immunized within their first birthday, reached 44.4 per cent in 1994, and increased to 46.9 per cent in 1997, but went stagnant after a decade[72]. Data of RISKESDAS indicated a lower level of immunization coverage among girls below 2 years, compared to boys. Further studies could be done on the performance of immunization programs and gender barriers.

Domestic violence and other social issues

Cases of violence against children, boys and girls, are widespread in the country and it is recognised as a significant gender issue. The RPJMN 2010-2014 document points out the prevalence of VAW cases in the country was about 3-4 million per year[73]. The National Commission on Anti Violence Against Women (Komnas Perempuan/KP) documented an increased number of reported violence against women (VAW). These can be interpreted both as the increased confidence among women survivors to report their cases, but also on the under reported of cases of VAW in the past.

[71] UNIFEM, Making the MDGs Work for All: Gender-responsive Rights Based Approaches to the MDGs, UNIFEM, November 2008, pp.92
[72] Combined data from UNICEF 2008 and RISKESDAS 2007 (2008)
[73] Data of SUSENAS 2006, BAPPENAS, RPJMN 2010-2014, 2010

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Cases of violence against women and children include child abuse, negligence, female genital mutilation (FGM), sexual assaults, rape and trafficking of children[74]. SUSENAS 2006 indicated that about 2.29 million children experienced violence against them[75]. Other causes of female adults' 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 is 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-sectorial approach. Some cooperation exists, for example in the development of inter-ministerial agreement to develop and implement a minimum service standard for cases of violence against women. Secondly, positive moves have been made in a recent enactment of a joint ministerial decree between the Minister of Health and the State Minister of Women 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 HSS program could contribute by ensuring 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, could be trained to pick up on signs of abuse at routine health visits and antenatal care. They should also be given knowledge about access/referral to services for the victims of violence. The HSS program could help address this issue by ensuring 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 has included mental health as one among the country's priorities, mental health services are not sufficiently able to respond to these challenges. There are also gender associations to 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 are directly related to the number of pregnancies a woman has lost, either due to abortions and miscarriages or due to child-death. The HSS program could play a role as the primary health care level may be appropriate for linking poor women with other services.

Barriers to accessing health for women

Issues preventing women accessing health services include: not knowing where to go, getting permission to go from the 'head of household', getting money needed for treatment, the distance to the health facility, having to take transport, not wanting to go alone, and concern that there may not be a female health provider present. (See

[74] Data from various reports from the State Ministry of Women Empowerment and Child Protection, Komnas Anak, Komnas HAM, and Komnas Perempuan.
[75] Ministry of Women Empowerment, Anak Korban Kekerasan (Fisik Dan Mental) Dan Perlakuan Salah (*Child Abuse), 2009*

Annex 2 table: *Problems in accessing health care: % of ever married women reporting big problems accessing health care*).There has been limited understanding among key leaderships of the risks of not taking into account the underlying determinants of gender inequality, and the specific socioeconomic and cultural barriers that prevent women accessing health care services. Education and knowledge sharing at this level is 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", with a projected figure of 314,500 people aged 15-49 people living with HIV in 2009. It is estimated that without accelerated efforts the country will have 541,700 HIV positive people by 2014[76]. 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 sexually transmitted infections (STIs) 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 5,170 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 (PMTCT) programs are not yet well established. Identified constraints include lack of information, lack of facilities for PMTCT and the stigma and discrimination HIV-positive pregnant women face when accessing health care services in hospitals, clinics and other health centres.

3. Gender and health

There is little data sex disaggregated data readily in the public domain on the health status, health risk factors or health care utilisation. It is difficult to piece together a gender based picture of health status. The data that is available shows a mixed picture. WHO provides some data which suggests that the male to female ratio of new smear-positive TB case notification is 1: 1.4 which is the lowest (i.e. most similar) in WHO's South East Asian Region except for Bhutan. It is lower than regional neighbours Malaysia (2.1) and Philippines (2.3).[77]

Overall cancer incidence rates in Indonesia are fairly similar for men and women according to 2010 data reported by Pfizer.[78] Breast cancer is the highest incident cancer among females in Indonesia (26.1 per 100,000 population) followed by uterine cervix cancer (15.7 per 100,000 population). Long and bronchus cancer are the highest incident cancer among males (20.0 per 100,000) followed by colon and

[76] Ministry of Health's AIDS report, 2008
[77] World Health Organisation. Global Tuberculosis Control, WHO Report 2010.
[78] Pfizer Facts: The Burden of Cancer in Asia. 2008

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. 61.7% of men over 15 years of age were reported as smokers in 2006, compared with only 5.2% of women over 15.[79] Worryingly there are similarly high prevalence rates of tobacco use among adolescents aged 13 – 15 of 41% for men and 6.2% for women.

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

The National Mid-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 at the end of developments in 5 years (2014), that there will be an increase in the Gender Development Index (*IPG*) - National plan RENSTRA 2010-2014.
The Ministry of Health has elaborated its mainstreaming strategy into some programs[80]. They are, among others:

- Assuring the implementation and operationalization of gender mainstreaming in all levels
- Developing rigorous sex disaggregated data
- Strengthening legal basis of gender equality promotion into the Ministry's work
- Implementing Gender Responsive Budget
- Carrying out gender awareness raising 'Socialization'.

In addition, there are some activities that will be carried out throughout this 5 year development plan. They are:

- Conducting gender analysis training (Gender Analysis Pathway) in all provinces
- Improving data base of the implementation of 'Kartu Menuju Sehat' (Health Development Card) for children under five, by gender
- Awareness raising on stopping maternal mortality using stickers
- Promoting Anti Malaria Program for Pregnant Women
- Introducing Clients' Participation for Eliminating HIV/AID
- Aiming to win "the Parahita Eka Praya" Award in gender mainstreaming
- Increasing Men's participation in contraceptive use
- Developing Gender related Training Modules.

The HMIS is tasked with managing various health data and indicators for monitoring the Healthy Indonesia 2010, MDGs, and other poverty reduction programs. Encouragements from the State Ministry of Women Empowerment for sectoral ministries, including MoH to collect data that are disaggregated by sex and gender, is useful and positive, but it is not producing significant changes or results. Basic

[79] World Health Organisation. World Health Statistics 2010.
[80] As presented in the Gender and Health's Round Table Discussions, 15 June 2010

data such as those on human resources of the MoH, have not been broken down by sex. Decentralization resulted in a partial breakdown of health information systems, due to an unclear division of reporting responsibilities.

Female doctors, midwifes, nurses, traditional healers, and volunteers form over half of 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 against their gender and professionalism. Indonesia has also had a female minister to chair the Minister of Health for two consecutive cabinet administrations. However, patriarchy norms and values are deep seated in terms of 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 role in the health system will 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 doctors training)[81]. Most of these tend to remain in urban areas on completion of their training and there is a lack of incentives to take up rural or more 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 in the RKA/KL of 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 increasing funding schemes for priority health issues including BOK (operating costs for PHC), 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, which was referred 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 having a normal delivery, about one fifth of the poorest women has 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 Askeskin Program[82], making them pay out of pocket for their delivery. Some reasons for the low coverage of the Askeskin have been the low access of those poor women to information about how to access and apply for the scheme[83].

[81] World Bank “Indonesia’s Doctors, Midwives and Nurses: Current Stock, Increasing Needs, Future Challenges and Options”, January 2009.
[82] Health insurance for the poor, Askeskin was once created in 2004.
[83] World Bank “Investing in Indonesia’s Health : Challenges and Opportunities for Public Spending”, 2008.

5. Partners for advancing gender equality in decentralised health services: national, provincial and district

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 HSS program should tap into existing health and local government structures and work with existing partners at all levels. Since decentralisation shifted more authority and responsibility to local governments for health care at primary levels, focussing 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 Ministry of Women Empowerment's Gender Focal Point. 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 also 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 district level will have the most significant impact on women and help address gender issues because they are 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 also be a good resource for generating health information from the community. Maximising and revitalising the work of the Puskesmas as effective and efficient service providers, as well as helping them act as knowledge resources on health issues, needs, and priorities that are faced by women and girls would be very useful. They can also advocate on these issues from a provincial level perspective, feeding up to national level. Similarly the district level BAPPENAS have a role to feed up to the national level planning cycles. Policy and technical guidance is retained by the Ministry of Health. At the next level, health centers and hospitals provide general services, and at the tertiary level are the larger hospitals and other specialized health institutions, which fit more with the wealthy demographic.

The participation of civil society, and particularly women's groups, health advocates and leaders, is critical. Their meaningful engagement at all levels of 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[84] on gender held as part of the research for the GASHI report some activities that could be incorporated in an HSS program were identified:

[84] Gender and Health's Round Table Discussions, organised by AusAID, 15 June 2010

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- It is vital to meet outcomes at 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 focussing 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 and need targets and measurements to monitor improvements and protect women't health status
- Adapt existing health policies and programmes to respond to specific gender needs.

7. Gender, decision-making, participation and accountability

For the health sector, decentralization offers both challenges and opportunities.[85] With their increased and accumulated revenue from the central 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 decentralization, some indications show that the local governments have not been able to fully utilise their increased budget. This is reflected inherent inefficiencies in budget planning and budget implementation processes.[86] Also, with local governments managing 40 percent of total public funds, the decentralization has made corruption more visible to citizens[87], requiring improved capacities of local actors to promote good governance and accountability through the effective management of funds.

The HSS programme would benefit from involving women's groups in the process of planning right from the outset. Consultations with representatives from the State Ministry for the role of women, the gender working group that currently exists within the MoH, and women's organisations/ 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 TA should also be consulted in the process and their inputs 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 becoming recognised as a country-wide issue, with a men's organisation

[85] *Government of Indonesia / UNDP 2006 – 2010 Country Program Mid Term Review*, January 2009
[86] In this respect, the GOI 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.
[87] The Asia Foundation, 'Decentralization and Local Governance in Indonesia", no date.

advocating gender quality launched in Jakarta in March 2011. The New Men Alliance (LLB) aims to promote awareness of women's rights among Indonesian men (The Jakata Globe). Men's specific involvement in reproductive health should not be overlooked.

Key issues to focus on in the first six months

The first priority for the design and implementation of the HSS program will be to ensure 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. This should be the basis for a gender strategy for the HSS program. Overall, when looking at gender needs in terms of the utilisation of primary health care services; several key issues stand out as being initial and most urgent points of focus.

Firstly, 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 here. Secondly, high infant mortality, extensive malnutrition (mothers and children) and low immunisation coverage all need addressing. Thirdly, diseases such as HIV/AIDS, TB, cervical cancer and breast cancer are the high threats to women's lives.

Secondly, 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 gender disaggregated health information and statistics from the community.

Thirdly, women need to be given a voice in decision making processes on the planning, delivery and monitoring of health services. This should include women practitioners, female politicians and public officials at the district level, and civil society women's groups. There is a particularly strong role for civil society women's groups in advocacy and in monitoring and accountability. This 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 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 indeed men's groups) should be consulted throughout the HSS planning phase, to ensure gender needs are met and taken seriously.

Overall, gender equality in the health sector is critical for the quality life of both women and men. WHO defines equity in *health status* as the achievement by *all people, women and men,* of the *highest attainable* well-being 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

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to the *ability to pay.*[88] Keeping gender as a consistent thread through all the HSS work will help address the issues of equity in health status in Indonesia.

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[88] Braveman, Paula, Op. Cit.; Wagstaff, Adam and van Dorslaaer, E., Equity in the finance and delivery of health care: concepts and definitions. In*: Equity in the financing and delivery of health care: An international perspective.* Edited by van Doorslaer, E., Wagstaff A., y Rutten, F., Oxford, Oxford University Press, 1993; Gilson L., In defense and pursuit of equity. *Soc. Sci. Med.* 47 (12) p.p. 1891-1898, 1998.

Annex 5: Institutional and Fiduciary Capacity Assessment

Introduction

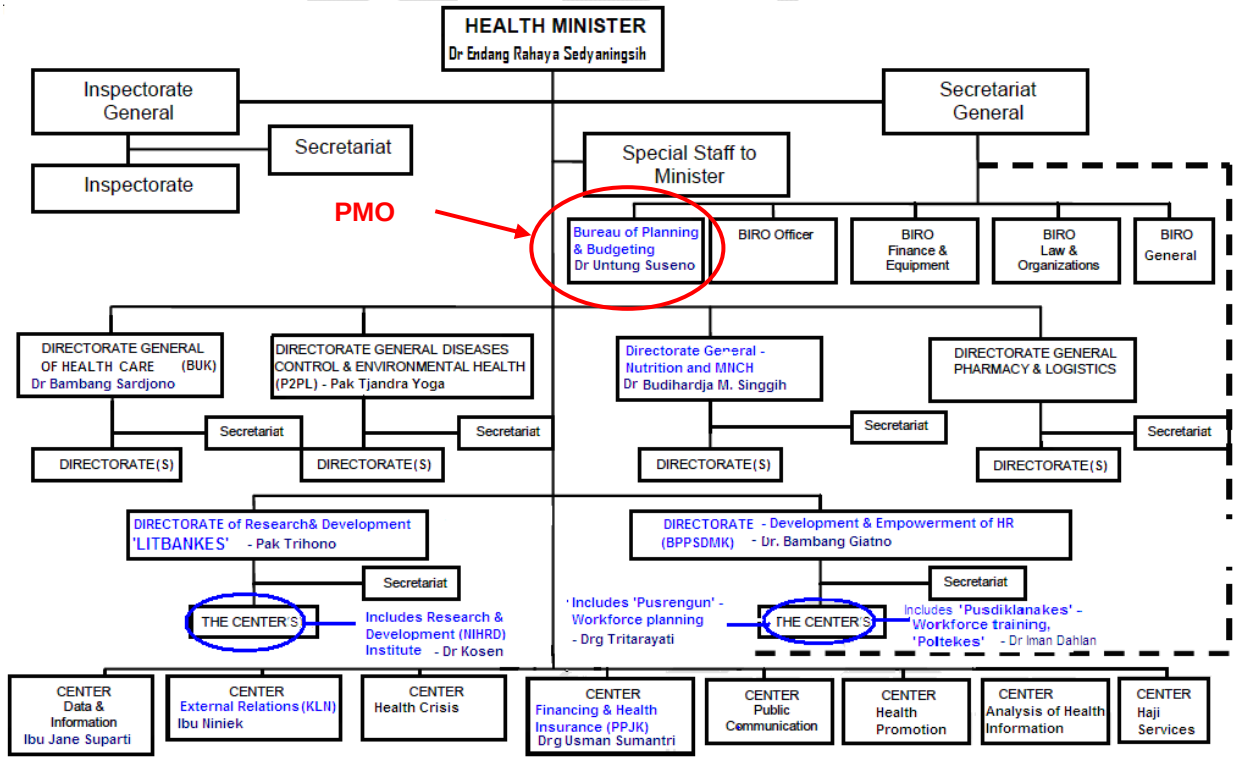
This annex summarises the institutional and fiduciary capacity of the key institutions that would have responsibility for management or implementation of the HSS program.

In particular it examines:

13. Have the most appropriate institutions been identified for the program?
14. The technical, financial and program management capacity of the key institutions implementing the program.
15. 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 1: Structure of the Ministry of Health



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1.1 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 and Program Management Office (PMO) within the Ministry of Health. The PMO will be in the Bureau of Planning and Budgeting. Ultimate responsibility for implementing and managing the program lies with the Secretary General of the Ministry of Health (as Chief Principal Recipient) and the ISP. The MOH and ISP will be receiving funding from AusAID, managing implementation and reporting (performance and financial) back to AusAID.

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

1.2 Institutions with a stake in policy issues

There are a number of ministries who set policy, regulations or norms that impact on health systems. These include BAPENNAS (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 at this stage that these ministries at national level will be responsible for managing the program and in particular for 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 (PMO) are best placed to provide technical oversight over 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, 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).

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2. Assessment of 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.

2.1 Ministry of Health (Program Management Office)

Technical Lead and Appropriateness for Program

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 Authorised 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 have working closely with AusAID in the development of this program. Their technical capacity to lead and manage this program is strong, but will be confirmed by an additional assessment to be done by the local funds agent (LFA – see below for further discussion).

Program & 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 PGS is (and will be) only used through other development partners do not trigger an assessment of PGS, since AusAID can rely largely on other development partners' assessments."*

However, we believe it is prudent to do some additional fiduciary checks on the Ministry, depending on the outcomes of the GF assessment (expected to be finalised in July 2011). The reason for this, is that the GF fiduciary risk assessment, conducted by the local funds agent Price Waterhouse Coopers (LFA), focuses on the Authorised Principal Recipient (APR) within the Ministry. For the Global Fund grant, this is the Centre for Data and Information, whereas for the AusAID HSS program, it is the Bureau of Planning and Budgeting.

Once we receive the LFA assessment, AusAID would identify areas of the assessment which are sufficient to meet AusAID's needs and also identify areas which need some additional analysis by the LFA. This work would be carried out in the second half of 2011. 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 GF and AusAID HSS programs will be similar (i.e. they are Ministry-wide rather than specific to the authorised principal recipient), however the program management capacity

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may differ. Therefore possible areas for additional LFA assessment may be needed, specifically on the key management responsibilities of the PMO such as: (i) developing annual work plans and budgets; (ii) developing annual progress reports; (iii) accounting for all program funding utilised by MOH and Provincial and District Health management units; (iv) managing provincial and district health offices (program and financial) (v) managing contracting and possible tendering for program resources and (vi) putting in place and implementing a clear M&E plan and ensuring (with assistance of others) collection of relevant baseline data. (See Annex 7 for more detail on NPMO responsibilities).

2.2 Provincial and District Health Office (PHO and DHO)

The Global Fund HSS program will work in 128 districts throughout Indonesia. The AusAID program is planning on just 20. These 20 districts are a sub-set of the GF HSS districts.

The LFA assessment tends to focus on the principal recipient (i.e. the MOH) rather than sub-recipients, however sub-recipients are assessed by the PMO, 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 PHO and DHO as sub-recipients.

2.3 Implementing Service Provider (ISP)

The ISP will provide TA, 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 TA 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 a 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 their funds and ensure the program is on-track. These oversight mechanisms will only apply for funds administered by the Ministry of Health and sub-recipients.

The Global Fund has a comprehensive system for financial and programmatic oversight of their grants. The Local Funds Agent (LFA) is a critical element in this. The LFA are the Global Fund's eyes and ears on the ground, making up for the fact

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that GF do 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 resource capacity and fiduciary of the principal recipient (prior to signing the Grant Agreement)
- Semi-annual program and financial audit by LFA, known as Verification of Implementation (VOI)
- Annual '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 2nd year of implementation to determine if the grant has been performing and should be continued
- Grant close-out report which 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 GF grants in a country carried out by a firm who is not the LFA. The second is a GOI audit, carried out by the Indonesian Supreme Audit Institution (BPK).

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

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Accordingly, the following table outlines which aspects of the Global Fund accountability mechanisms AusAID will employ for HSS.

Global Fund	AusAID
PR Assessment	AusAID will make an assessment on the quality of the GF LFA assessment once it is completed to determine if additional investigation is required.
Semi-annual program and financial audit by LFA	AusAID to commission LFA to do this for AusAID HSS funds as well. Explore further with GF 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 AusAID HSS funds as well. Explore further with GF whether this could be done jointly.
Two annual audits. External audit commissioned by the Global Fund, and GOI 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 sub-recipients.

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

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Annex 6: Proposed Program Activities

Introduction

This annex outlines the proposed program activities for each output in the Australia Indonesia Health Systems Strengthening (AIHSS) Program. This annex summarises the key activities that have been discussed with the Ministry of Health as being most essential to contribute to achievement of the program outputs. It draws upon the health systems analysis (Annex 1) and the problem analysis (Annex 9). It also draws upon the experience of the Australia Indonesia Partnership for Maternal and Neonatal Health because there are many common issues to be addressed due to the high degree of linkage between the strength of health systems and the achievement of maternal health outcomes.

The activities listed in this annex are an indicative list. They reflect and signify a common understanding between AusAID and the Ministry of Health on the outputs that the program intends to achieve at the end of the program, and a common understanding on the key activities and inputs required to achieve those outputs. They are indicative because further more detailed needs assessment is required, the participation of provincial, district and puskesmas staff in identifying needs is required, and a prioritisation based upon 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.

It is anticipated that the first activity of the Program Management Office and the Implementing Service Provider would be to organise consultation with sub-national stakeholders and develop a prioritised and budgeted workplan which draws upon but refines and improves the activities outlined in this annex. The activities are presented in two categories: (i) most urgent and important that should be strongly considered for implementation in the first year of the program and (ii) medium term activities requiring further consideration.

The activities are presented below 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.

Output 1: Ministry of Health using evidence-based data and up to date information for the national level policies' decision making on health financing and health human resources to improve access and quality of primary health care for the poor and the near poor.

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This output will require activities to (i) build the capacity of the Ministry of Health to demand and commission poverty related research, (ii) use that evidence to inform policy and strategy documents and (iii) improve the information system on human resources for health.

Output Indicator 1.1

Increase in the number of demands from MoH (and other ministries) for poverty relevant studies, data and information; OR

Output Indicator 1.2

1. 2015 national health strategy linked to national needs and priorities which includes explicit measures to improve the health of poor and near poor.

2. Program generated evidence and data referenced in policy briefs, documents and national strategic plan.

The Minister for health has established a Health Policy Unit within the Directorate of Research and Development (*Litbankes*) to support evidence based policy decisions. In order to fulfil its mandate an assessment of the evidence to policy link within the MoH and between the *litbankes* and programs is required. Following this assessment further training and technical assistance can be provided to 1) *Litbankes* and 2) planning, policy and program areas within the Ministry in framing research questions, reporting and dissemination of results. Support to the Policy Unit would also include commissioning policy research and providing quality policy briefs including: demand driven research, over the horizon research and evidence to support the next government strategic health plan when the 2010-2014 plan expires.

By tracking the amounts, source and use of funds throughout the system it is possible to make decisions about allocations to areas of strategic priority and configure health financing systems to maximise efficiency and achieve health outcomes. Through the regular production and dissemination of a National Health Account, health funds will be quantified and their flow through the system mapped at the macro level. District health accounts, formulated in the 20 selected poor districts will provide a greater level of detail about use of funds at the mid-level of the system. National Health Account Work is expected to become fully sustainable by 2013; however activities to support dissemination of information and use by other Ministries may extend beyond this period.

Output Indicator 1.3

The health human resources information system provides data to support national, provincial and district management

Having the right health personnel in the right place at the right time is an important pre-condition for accessible, quality primary health care. Indonesia is seeking to improve the planning, distribution and quality of the health workforce, particularly in underserved and poor regions, and has established a whole of government

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coordination mechanism to achieve policy and planning coherence at the national level. While national level decisions have a significant role in determining workforce supply and distribution, in the context of decentralised health service administration, districts also have a major role in data collection, policy and planning.

Information about the type and location of the health workforce is a necessary input to decision-making so that the workforce can be distributed according to need. Global Fund supported work underway within the Ministry of Health to improve health information systems will influence the broader organisational context (awareness, motivation, leadership) in which the health workforce data will be used.

Five key areas of work are required to deliver on this output:

- a needs assessment will identify why current HRH information and planning is not working? Priority objectives of an effective HRH info system are defined, audit of key user needs. Data mapping – what databases and information is available and how best to use it?
- Support for developing an overview of human resource workforce situation in the country drawing on all the existing databases to give MoH clear understanding for future planning and workforce training needs, to include distribution of staff and dual practice (the former harmonised database activity).
- TA to the Directorate for Development and Empowerment (*Pusrengun*) for strategic planning on human work force including future mapping and analysis of effectiveness of existing human work force regulations (maybe start with inception phase scoping work). Could include planning future national training needs, impact of regulations on human resource distribution and review of existing health workforce classifications (PNS, PTT) policies to see if they are adequately meeting Puskesmas staffing needs.
- Support to secretariat of the cross government Committee on Health Workforce CCF – the multi-ministry committee which is looking at human resources across government. Possible support for some of its activities or research on issues relevant to poor people and PHC.
- Commission study on the continual turn over at staff at all levels of the health system Mutasi – its causes, implications and develop options for addressing it (to include short term mitigation measures and medium term policy options)

Output 2: Twenty districts/city health offices in five provinces implement health financing and human health resources' policies and programs more effectively and efficiently to improve access and quality to primary health care for the poor and the near poor.

Achievement of this output will require activities to (i) build the capacity of the Provincial Health Offices to lead, supervise and catalyse improved District Health Office management of financial and human resources , (ii) build systems and capacity of District Health Offices to make more efficient and effective use of financial and human resources and (iii) improve the information system on human resources for health. This is a list of possible activities but further consultation is

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required by Ministry of Health with representatives from provincial and district health offices, and from primary health care providers.

Output Indicator 2.1

20 district/city health offices making annual health plans with a performance framework which includes measures to improve health of poor and near poor people and reporting annually.

As local representatives of the national government, provincial health offices (PHO) can more effectively guide, supervise, and facilitate districts to improve health planning and health service delivery. It is proposed that technical assistance be provided to provinces to strengthen their role in supervision and stewardship, following a needs analysis of PHO capacity. Improving PHOs' own capacity to develop health plans and adopt tools for rigorous performance management is expected to directly impact on districts' capacity to improve development of their own health plans. Improving health planning that underpins service delivery includes supporting innovation – such as thinking and planning for outreach services to support PHC in remote areas and small islands – where provinces/districts supported through the program need strategies that address their unique situations. This could include funding for provincial schools of public health to develop a health planning and budgeting course for provincial / district health offices with the provincial health office that can be rolled out to all districts. In this way support provided through the program can impact more widely than the within the selected districts.

Mutasi, or the transfer of public servants from one position to another, may impact on the gains expected from the support to the PHO and DHOs. Options to approach this issue include commissioning a study on Mutasi – its causes, implications and to develop options for addressing it - which would include short term mitigation measures and medium term policy options. Measures could include support for advocacy to decision makers and providing evidence on the impact of mutasi to the national level (link to Output 1).

Other support to the following areas include:

- TA and support to PHO / DHO to commission:
    - Survey on health seeking behaviour to understand what is required to make health services more accessible and attractive to the poor.
    - Survey/research on identifying who is poor and vulnerable and whether they are benefiting from national / district funding programmes (Jamkesmas, BOK, Jampersal, Jamkesda).
    - Specific activities on gender related issues to ensure health services are appropriate for both women and men.
- Clinical training and provide mentoring and/or facilitator to assist the PHO/DHO officials to implement the health program;
- Activities to improve the surveillance on evidence based planning

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- Referral network forum – district planning for coordination among puskesmas and district health office. Establish a coordination or working group (Pokja) to facilitate discussion with Puskesmas and PHO/DHO officials.

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).

To improve the likelihood that increased health budgets lead to improvements in health outcomes, the program aims to support training at the district level to better use evidence to develop health plans and budgets and disburse the health budget on time. To address the increased fragmentation of health budget lines which impact on the effective access to and use of budgets, technical assistance or a study to support integration of Jamkesmas, Jampersal and BOK can be used to facilitate improved budgeting and higher budget utilisation rate (possible link with national level work). It is anticipated that AusAID support for District Health Accounts (DHA) be continued on the proviso that a succession plan for MOH to continue this work be effective and implemented by 2013. Support for DHA includes their development and use by DHO to improve resource allocation at the district level (pre-implementation activity with UI). It also includes training to DHO to use DHA to advocate for increased district health budget – including using media and local civil society and local parliamentarians.

Output Indicator 2.3

1. Number of primary health care facilities with minimum midwives and nurses to provide core services in line with district plan,

As key to delivery of primary health care, support will be provided to puskesmas to improve services and demand from the community in need of these services. Management capacity at the puskesmas level has been identified through the AIPMNH program as a core need to address improved service delivery. This includes training in standard competency modules as well as additional skills for public finance management. The burden on puskesmas staff of multiple reporting requirements impacts on the capacity to provide care to the community, and as such technical assistance to develop and trial mechanisms to streamline multiple reporting requirements from puskesmas may be supported and linked to the development of puskesmas management training modules. A needs assessment may initially be undertaken to identify requirements and establish the success of approaches taken through programs such as AIPMNH. The needs assessment would include a focus on both workforce and equipment.

Other support may include:

- 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.

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- Demand and supply side assessment of health workers so that PHO/DHO will be able to know the number of required midwives and nurses and develop "local perdas" if needed. This is also link to capacity of PHO/DHO for health workforce planning

(Possible supplementary indicators for this output are:

2. % of staff in district with agreed job description who receive annual performance appraisal.

3. % of staff in post when they should be.)

There is a need to review current provincial/district capacity to manage and implement HRH policies. District Health Offices (DHO) will be supported to map the HR situation and needs and to develop plans to address gaps (including PTT, honor, incentives etc), and training will be provided to DHOs to introduce and strengthen performance based funding for Puskesmas for priority health services. Technical assistance or studies to assess issues such as dual practice may be undertaken for their impact on health service delivery.

Output 3: Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in twenty districts/cities in five provinces having (empowered) qualified health workers and have sufficient resources to deliver quality and free primary health care services and referral for the poor and the near poor (Puskesmas to Poned).

Achievement of this Output requires implementation of activities in Output 2 above to address district health office 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 Ministry of Health with representatives from provincial and district health offices, and from primary health care providers.

Output Indicator 3.1

1. Reduced out of pocket expenditure by poor people attending Puskesmas; OR

2. Benefits incidence of public funding

Activities identified for Output 2 will contribute to achievement of this activity – in particular those focusing on improving the realisation and disbursement of health budgets and the targeting of public health funding to benefit the poorest.

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Output Indicator 3.2

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.

There are a range of potential activities to improve the readiness and quality of primary health care services delivered by Puskesmas. The precise needs will vary from district to district. Health workers will be trained to understand and make better use of existing regulations and quality standards, in particular with regard to ante-natal care, delivery referrals, immunisation, IMCI, TB. This will entail Puskesmas introducing quality audits for key priority interventions and Integrating immunisation and ANC; nutrition, weighing of under-5's, immunisation - should be covered under Health worker training. Experience from AIPMNH suggests that activities will be required to develop and better manage referral pathways especially for Emergency Obstetric Care (see Output 2 above).

Additional activities might include

- Work to strengthen the use of Essential Drugs List at puskesmas level.
- Audit conducted to identify other essential factors required to support Puskesmas staff effectiveness
- Antenatal care needs assessment to understand why not all pregnant women are completing ANC.

Output Indicator 3.3 and 3.4

3.3 Proportion of Puskesmas budget from all national, provincial and district sources disbursed to puskesmas each month or quarter

3.4 Distribution of health workers matches planned allocation for primary health care facilities based on occupation/speciality, geographical, demographics.

Most of the activities to achieve these two indicators will be undertaken at district and provincial level and have been outlined above. In addition there will be training for *Puskesmas* manager and admin staff trained to produce plans and budgets and to report performance.

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. Achievement of this output will involve: (i) support to Ministry of Health to oversee and lead introduction of new accreditation standards for Poltekkes, (ii) support to 5 Poltekkes to improve their nursing and midwifery training course standards.

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Output Indicators 4.1 and 4.2 and 4.3

4.1. Five Poltekes are successfully accredited and graduates are employed in poor or rural districts

4.2 Annual number of midwife and nursing graduates per 100,000 populations from 5 Poltekes under new accredited courses

Poltekes in target provinces will be assessed against new accreditation standards and assistance provided to the Training and Accreditation unit in the MoH to improve: curricula, teaching methods, and infrastructure to meet new nursing and midwifery standards. Poltekes will receive funding to upgrade facilities to meet new nursing and midwifery standards. The interventions will include:

- Needs assessment of MoH capacity to support Poltekes (Prodi) to meet new accreditation standards and priority Poltekes (nursing and midwifery Prodi) of the assistance (infrastructure and TA) required enabling them to meet the new accreditation standards. Should focus on needs for midwifery and nursing courses to meet new standards, as well as for the Poltekes overall.
- Technical assistance for a body (MOH or contracted university or other provider) to develop the tools and methodologies and experience to support MoH and Poltekes (Prodi) to meet new accreditation standards. Objective is that this body does this for first 5 Poltekes with AusAID support and then has tools and methods for MOH, MONE or Poltekes directly to purchase their technical assistance for roll out across all Poltekes (Prodi).
- Grants and TA to Poltekes (Prodi) in 5 selected programme provinces to implement activities to meet accreditation standards (upgrading infrastructure and technical assistance on issues identified in needs assessments). (good candidate for outputs based funding)
- Demand and supply side assessment of Poltekkes and link to Output 1 and Output 2 (evidence based policy at national and sub national including better data)

Output Indicators 4.3

4.3 Proportion of annual graduates who take up employment in poor or rural districts

Achievement of indicator 4.3 will be mostly dependent upon achievement of activities listed under Output 2 for improving the management and distribution of health workers at district level.

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Output 5: Universities, research institutes, civil society organizations are able to deliver evidence-based data and advocate the central and local policy-makers on health financing and health workforce and provide TA and training to districts and Puskesmas to increase health access for the poor and the near poor people.

Achievement of this output will require universities and research institutes (i) to develop the capacity to conduct research on the health of poor people, (ii) to make evidence and research available to policy makers in an accessible format and (iii) to develop and deliver training and assistance to provincial and district health staff. It will require involve civil society being funded to (i) advocate for increased health funding for poor people, (ii) hold health offices and primary health care providers accountable for the services they provide and (iii) conduct research to inform health advocacy and policy.

Output Indicator 5.1

5.1. Number of studies and policy relevant publications which can show use of the evidence in policy decision-making.

Health systems reform in Indonesia is dynamic and there are a number of important areas that are emerging or are evolving rapidly. A number of initiatives are underway to strengthen the relationship between government and research institutions in health. The development of centres of excellence in primary health care for the poor research will increase the knowledge base of primary health care to inform policy and practice through the conduct and support of research; facilitate the uptake of evidence in primary health care policy and practice; and enhance research capacity in primary health care through competitive research undertaken through strategic partnerships and collaborations with other relevant national and international groups.

This output closely links to output one and in the first instance a needs assessment will be undertaken for Health Policy Network , to finalise its terms of reference and implementation mechanism. Technical assistance and funding will be provided to support the development of network of major universities, research institutes and provincial schools of public health into centres of excellence. Support to the network will include:

- technical assistance support (i) training on writing a policy briefing and presenting evidence to policy makers and (ii) funding for research in key identified areas (e.g. poverty, 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 meetings and workshops, roundtables and policy meetings to disseminate results bring evidence to policy – especially MNH

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- Funding and TA to Health Policy Network to develop stronger regional health policy research capacity in institutes that can support PHOs and DHOs in policy making.

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 level.

Civil society groups can play an important role in generating and using data and evidence to advocate for improved primary health care for poor people and also to work with communities to generate demand for improved primary health care service delivery. Fostering civil society including professional and women's organisations ability to respond to and demand better pro-poor health policy will be a focus of the civil society funding.

A civil society challenge fund will be established jointly with the MoH and managed by ISP to provide grants to CSO to advocate for health services for poor people in areas such as raising awareness of Jamkesmas and entitlements, monitoring performance of local health authorities and local health facilities (to improve accountability) (links with Outputs 2 and 3). In the medium term this could evolve into support for the establishment of a civil society network or umbrella organisation to help organise and coordinate CSO participation in health policy discussions.

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Annex 7: Program Governance, Management and Implementation Arrangements

Introduction to the Modality

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

The program will be implemented through an Implementing Service Provider (ISP) and Program Management Office (PMO). The PMO will sit within the Ministry of Health and administer AusAID 'ring-fenced' 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 the over this program led to the consideration of a modality which would 'put GoI in the drivers' seat'
- 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 5-year, USD $37 million health systems strengthening grant for Indonesia, focusing on pharmaceutical supply chain and information management)
- The likelihood that a joint approach provides greater leverage for AusAID funds
- Australia's broader interest in the Global Fund as a significant donor and interest in encouraging the GF to pursue health systems strengthening alongside their vertical programs
- AusAID as major donor in Indonesia and major donor to the GF, have a strategic interest in ensuring the success and coordination of HSS work in Indonesia
- To maximise complementarities, efficiencies and synergies

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- Minimise transaction costs on the Ministry (the Global Fund has successfully used GoI systems to execute $340 million of grants)

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

1. Rationale for Aid Modality Selection and Design
2. Oversight arrangements which are clear, involve Government of Indonesia and AusAID in joint accountability for strategic decisions on the performance and direction of the program
3. Management arrangements which emphasise national leadership and ownership and which delineate responsibilities clearly to ensure 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.

Rationale for Aid Modality Selection and Design

The program design process considered a number of options for aid modality and implementation mechanism. The criteria used to assess the strengths and weaknesses of the different options are: (i) most likely to support achievement of program outcomes, (ii) most likely to support national ownership and leadership, (iii) robust financial risk management – protecting AusAID $ from misuse or leakage, (iv) maximises AusAID - MOH policy dialogue, (v) minimises transaction costs for AusAID and MOH, (vi) flexible to allow scale up with additional resources in the future, (vii) possibility to extend beyond immediate 5 year programme, (viii) capacity to accommodate other potentially interested donors, (ix) based on international best practice and (x) feasibility to start quickly (early 2012).

The other forms of aid considered included:

- partnering with a development Bank, in particular the World Bank but also possibly the ADB;
- partnering with a UN agency;
- sector budget support; or
- 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 which could enable strong government ownership and robust financial risk management. It positions AusAID very well for future additional financial support in a Phase II after 2016 by (i) enabling AusAID to develop credibility and a track record in supporting government to strengthen health systems, (ii) provides AusAID with a platform for a strong policy dialogue with government, (iii)

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enables testing of use of national systems for AusAID funding in a relatively safe environment before considering greater scale up support.

The strongest alternative option would have been a World Bank Trust Fund. This was discounted because of the low interest on the part 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 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 ensure 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 is unlikely to achieve the high level of partner government ownership and leadership required. Sector budget support was discounted for two main reasons: firstly it does not score well against the financial risk management criteria, and secondly there is the risk that AusAID funding, by being relatively small 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 principle benefits of this approach are: (i) use of the existing and proven Global Fund aid management model which is country led but with strong fiduciary risk management, (ii) potential synergies to the Government of Indonesia of bringing two HSS funding streams in alignment with national priorities; (iii) complementarity of AusAID support for human resources and health financing, with Global Fund support for health information systems and pharmaceutical supply chain management and (iv) the potential for AusAID to influence implementation of Global Fund support and leverage greater outcomes – 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: (i) Global Fund's slow grant disbursement record limiting impact of its funding, (ii) global perceptions of misuse of Global Fund grants being applied to Indonesia (real or perceived); (iii) increased transaction costs for AusAID staff in policy dialogue and managing key national level relationships – aid coordination always takes more time than envisaged. On balance AusAID, the Ministry of Health and the Global Fund agreed that the partial harmonisation approach should bring benefits and can minimise the risks.

Overview

The AusAID HSS program will be delivered through two modalities: An ISP and a through 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 as well.

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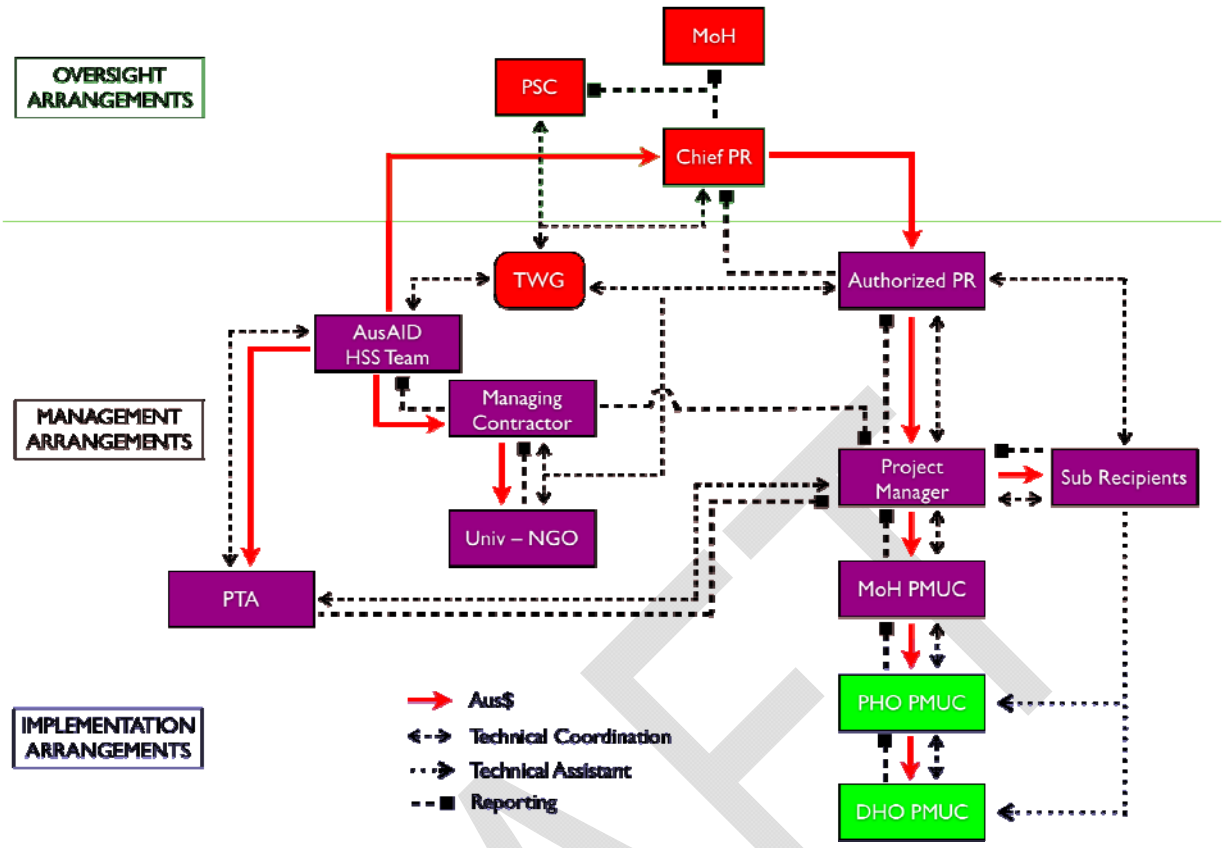

This diagram is a result of a process of negotiation between Ministry of Health and AusAID. Consequently the diagram has some terminology which may be different from the following Annex, but the principals are largely the same. Details of roles and responsibilities of positions are set out in Attachment 1.

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 (CPR) is the person whom the Minister of Health bestows the authorization to manage – technically and administratively – both the AusAID and GF HSS grants, and reports directly to the Minister of Health. The CPR is the Secretary General of MoH.

The second oversight mechanism is the joint *AusAID-GF HSS Technical Working Group (TWG)*. This group will ensure consistency between the AusAID and GF HSS programs and also to ensure that the HSS grants are in-line with the Ministry's priorities and supporting their work. This group will comprise of Echelon 2 and 3 staff from various directorates and bureaus across the Ministry, with a shared interest in

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health systems strengthening and primary health care. The HSS M&E 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 *Program Steering Committee (PSC)*.

The PSC has responsibility for setting the program's strategic direction and monitoring progress. It should ensure that the HSS 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 Ministry of Health, 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 Ministry of Health Departments, DG International Cooperation, BAPENAS, Ministry of Finance, Ministry of Home Affairs, AusAID, representation from some of the provinces and districts. The Ministry of Health will nominate its representative to chair the PSC. It is anticipated that the PSG 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.

Management arrangements

AusAID has identified separate management arrangements from the GF HSS grant. This is because the focus areas of the two HSS programs are different and therefore the location of the Authorised Principal Recipient and Program Manager should reflect the areas of focus. Accordingly, AusAID HSS 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 *Authorised Principal Recipient* (APR) and *Program Manager* (PM) will be different for the Global Fund HSS and AusAID HSS grants. The reason for this is that although both Global Fund and AusAID are working on health systems strengthening, they are focusing on different areas within HSS. The Global Fund proposal focuses on information management and pharmaceuticals, and is managed in the Centre for Data and Information Management (Pusdatin). The AusAID HSS 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 Advisor (PTA)* will be employed by AusAID to support the Program Manager. Specifically, they will support the PM in evaluating Plans of Actions from sub-recipients 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 PTA will also oversight

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workplans from the ISP to ensure consistency between all program activities. For detailed TORs for the PTA, see attachment 5.

Implementation arrangements

The Global Fund has disbursed around $340 million of grants in Indonesia since 2003, including $300 million to the Ministry of Health. Their procedures for program and financial management are well established. There have been no problems with disbursements of funds since 2007[89]. The Local Funds Agent (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 GF processes, MOH and sub-national authorities are familiar with GF procedures. In addition, the GF does not seem to be plagued with some of the problems like 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 GF and AusAID HSS grants will follow the Global Fund's implementation procedures.

Program Management Office (PMO)

AusAID will establish a PMO in Bureau of Planning and Budgeting. The management responsibilities of the HSS 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 M&E 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 & TWG meetings.

For a more detailed TORs, see Attachment 2.

[89] There was a problem in 2006 with a sub-recipient, but this was resolved and there are now more stringent controls of sub-recipients and tighter oversight by LFA.

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AusAID will provide funds for staff in the PMO to manage the AusAID HSS funds. Staff within the PMU will adopt and follow the GF processes for financial management, activity implementation, accounting, and auditing for the GF and AusAID grants. There will be very close cooperation between the PMO for AusAID and GF HSS programs, potentially even co-location of offices.

The PMU would be led by a national program manager who reports to 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 ring-fenced from both GF HSS funds and Ministry of Health funds. They will be held in a separate bank-account. A more detailed diagram outlining the funds flow/disbursement arrangements is Attachment 3.

AusAID will contract a Program Technical Advisor who will work closely with 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.

The Global Fund provides salary for non-public service staff and incentives for ex-officio staff to perform additional roles in managing or implementation of Global Fund Grants. AusAID plans to use the same pay scale and incentives (Attachment 4 provides the extract from the 2010 Ministry of Health PIM) to give indicative costings. We note that payment of incentives is an issue that the Global Fund has identified they are interested in reforming so AusAID decision making on this matter will remain in-step with the GF.

Because AusAID are proposing to use the GF implementation arrangements, there are a number of important steps which will need to be done during the inception phase, which the PMO will need to disburse the grants:

- PMO to develop a Program Implementation Manual (PIM).[90] The PIM 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 (PR), sub-recipient (SR), sub-sub recipient (SSR) and Implementing Units under the coordinating of the PR. The PIM also includes: salaries and incentives; procedures for establishing and clearing accounts; details outlining processes and procedures for procurement (including business trips; seminars; funds disbursement mechanism).
- PMO to develop consolidated workplans/ plans of action from SRs
- Detailed costing and activity plans, similar to the detail in the GF Round proposal

[90] The PIM for the GF and AusAID HSS grants may be the same document. However, this will need to be confirmed with the CCM.

- PMO to develop a procurement plan (to be reviewed by the LFA)
- PMO to develop Sub Grant Agreements for Sub-Recipients (based on GF)
- PMO to develop Agreements on Performance of Work (APW) (based on GF)
- AusAID to contract LFA to provide financial and program oversight as outlined in Annex 5.

Implementing Service Provider (ISP)

AusAID will contract an ISP to provide TA, 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 Authorised Principal Recipient and Program Manager, with support from the Program Technical Advisor.

Other Links with Global Fund and Country Coordination Mechanism

The Global Fund supported HSS program will have the usual Global Fund oversight and governance arrangements through the Country Coordination Mechanism which the AusAID HSS program will not. However it will be important for there to be some structured links between the two programs to: (i) enable additional benefits coming from identifying potential synergies and joint planning, where appropriate, of complementary activities and (ii) ensure strategic oversight of both programs contributes to strengthening Indonesia health systems and domestic funding channels.

Specific links could / should include:

- AusAID is already active on the CCM, continue this role
- AusAID, Global Fund and MOH agree a trilateral Memorandum of Understanding on intentions and communication between the three parties, including potential for shared program evaluation and oversight missions
- Global Fund PMU and AusAID PMO to meet monthly to coordinate
- PMO align planning cycles to seek potential synergies and jointly plan where appropriate.

Sub-National Levels

The program will be delivered sub-nationally through provincial and district health offices (PHO and DHO). Depending on the nature of the activity, technical assistance may be provided by the ISP or else funds will be channelled from the MoH to PHO and then DHO to implement previously agreed workplans.

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The PHO and DHO receiving grants must follow procedures outlines in the PIM and must also sign sub-grant agreements for sub-recipients. They will be subject to oversight and audit by the LFA.

Strengths and Weaknesses of this Approach

The following table sets out some of the strengths and weaknesses associated with the proposed modality. Responses to weaknesses will be addressed in the risk management matrix.

Strengths

- 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 OCED 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 GF HSS activities
- Potential to influence and leverage value from GF support

Weaknesses

- Potential fiduciary risk of financial management and accountability of government systems
- May take time to set up national management systems (from MOH to province and districts)
- If GF grants are not well managed or open to suspicion of mismanagement, this could tarnish the reputation of the AA HSS program
- Risk of diluting policy dialogue if GF presence and influence is greater

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

No	Role	Person in Charge	Task and/or Responsible
1.	Authorized Person in Delegating Power	Minister of Health	Authorized 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 & Budgeting + Head of Central for Int'l Coop. + Head of AusAid Rep.	• Approve review report every six months • Approve evaluation report every six months • Give direction and input to the AIPHSS program implementation • Reports directly to the Minister of Health
3.	Chief Principal Recipient (Chief PR)	Secretary General	• 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 sub-recipients
4.	Technical Working Group (TWG)	Focal point from each sub-recipients and AusAID Health Policy Advisor	• Provide technical inputs to APR and PSC in terms of HSS program planning and implementation • Provide technical inputs to the proposed work plan from SR and MoHPMO
5.	AusAID HSS Team	AusAID HSS team	• Transfer fund to the MoH special account under the Chief PR supervision • Transfer fund to the PTA and ISP
6.	PTA (Program Technical Advisor)	Third party, appointed by AusAID	• Provide technical inputs to ISP and PM on HSS program planning and implementation • Coordinate with the AusAID HSS

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			team • Report to AusAID and PM
7.	Implementing Service Provider (ISP)	Third party, appointed by AusAID	• 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 APR, for program implementation technical assistance • Coordinate technically with the PTA • Report to the AusAID HSS team and PM
8.	Authorized Principal Recipient (APR)	Echelon 2 (appointed by Chief PR)	• Manage AusAID fund channelling through the PM • Report to Chief PR • Authorize sub recipients fund usage • Coordinate with AusAID via TWG
9.	Program Manager (PM)	Echelon 3 (appointed by Chief PR)	• Report to Chief PR via APR • Take part as the officer accountable for the commitment • Review the proposed programs from sub recipients and MoH PMO • Arrange the fund channelling to sub recipients and MoH PMO
10.	Sub Recipients	MoH Technical Unit	• Plan the HSS program • Report to PM • Coordinate technically with PM & APR • Giving technical assistance to PHOPMO and DHOPMO

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			• Responsible administratively and financially to PM and APR
11.	MoH Program Management Unit Coordinator (PMO)	Bureau of Planning and Budget Staff/civil servant retiree, working full time, pointed by Chief PR	• Organize AusAID fund • Report to APR via PM • Assisted by related units such as human resource, logistic, finance, and monitoring and evaluation
12.	Provincial Health Office PMO (PHOPMU)	Staff/civil servant retiree, working full time, appointed by Chief PR	• Perform provincial program planning • Monitor program implementation at province • Report to MoH PMO, assisted by 2-3 staff to perform tasks related to human resource, logistic, finance, and planning
13.	District Health Office PMO (DHOPMU)	Staff/civil servant retiree, working full time, appointed by Chief PR	• Perform district program planning • Report to PHOPMO, assisted by 2-3 staff to perform tasks related to human resource, logistic, finance, and planning

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

The PMU is the unit under the Program Manager of Principal Recipient who responsible for managing finance, Monitoring and evaluation, HRD, Procurement Supply and Management (PSM) and administration of the program. The PMU is led by PMU Coordinator who has tasks and responsibilities as follows:

a. To coordinate the work of the program management units, namely Human Resource Development, Finance, Logistics (including procurement and supply management), and Planning, Monitoring & Evaluation.

b. To lead and facilitate the development of work plans and Plans of Action (POA) by the PR and SRs.

c. To be responsible for the general and financial administration of the program, including the verification of expenditures and financial reports.

d. To lead the analysis and assessment of financial and program performance based on monthly reports and quarterly achievement indicators and disseminates the results to each unit for follow up and proposed action to be taken to the Program Manager.

e. To co-authorize payments at PR level in conjunction with the Program Manager and the Principal Recipient. All payments must be authorized by two of three authorized individuals: the Principal Recipient, the Program Manager and the PMU Coordinator.

f. To co-sign cheques with the Authorized Principal Recipient (APR) and/or the Program Manager for cash withdrawals for program funded by AusAID expenditure.

g. To authorize finance staff to transfer funds to Sub-Recipients.

h. To be responsible for timely, accurate and safe disbursement of funds to Sub-Recipients.

i. To provide guidance for Sub-Recipients on activity implementation and monitor their compliance with the terms of the Sub Grant Agreement and GFATM requirements.

j. To be responsible for the implementation of the PR's audit of the financial performance of SRs and to monitor the SR's internal audit as required.

k. To lead logistics planning relating to program funded by AusAID

l. To develop Sub Grant Agreements for Sub-Recipients based on GFATM requirements.

m. To develop Agreements on Performance of Work (APW) as well as other documents required in relation to GFATM funding.

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n. To be responsible for the availability and integrity of all program documentation, including supporting documents for use of funds.

o. Maintaining and storing all financial documents for at least 5 (3) years, based on the grant agreement.

p. To work closely with SRs and the Program Manager and Principal Recipient to take early action on issues arising in management and implementation, based on the findings of the internal or external audits, the LFA, and the PMU's own monitoring.

To protect against conflicts of interest by following the procedures articulated in the Program Implementation Manual (PIM) within the scope of his/her responsibilities.

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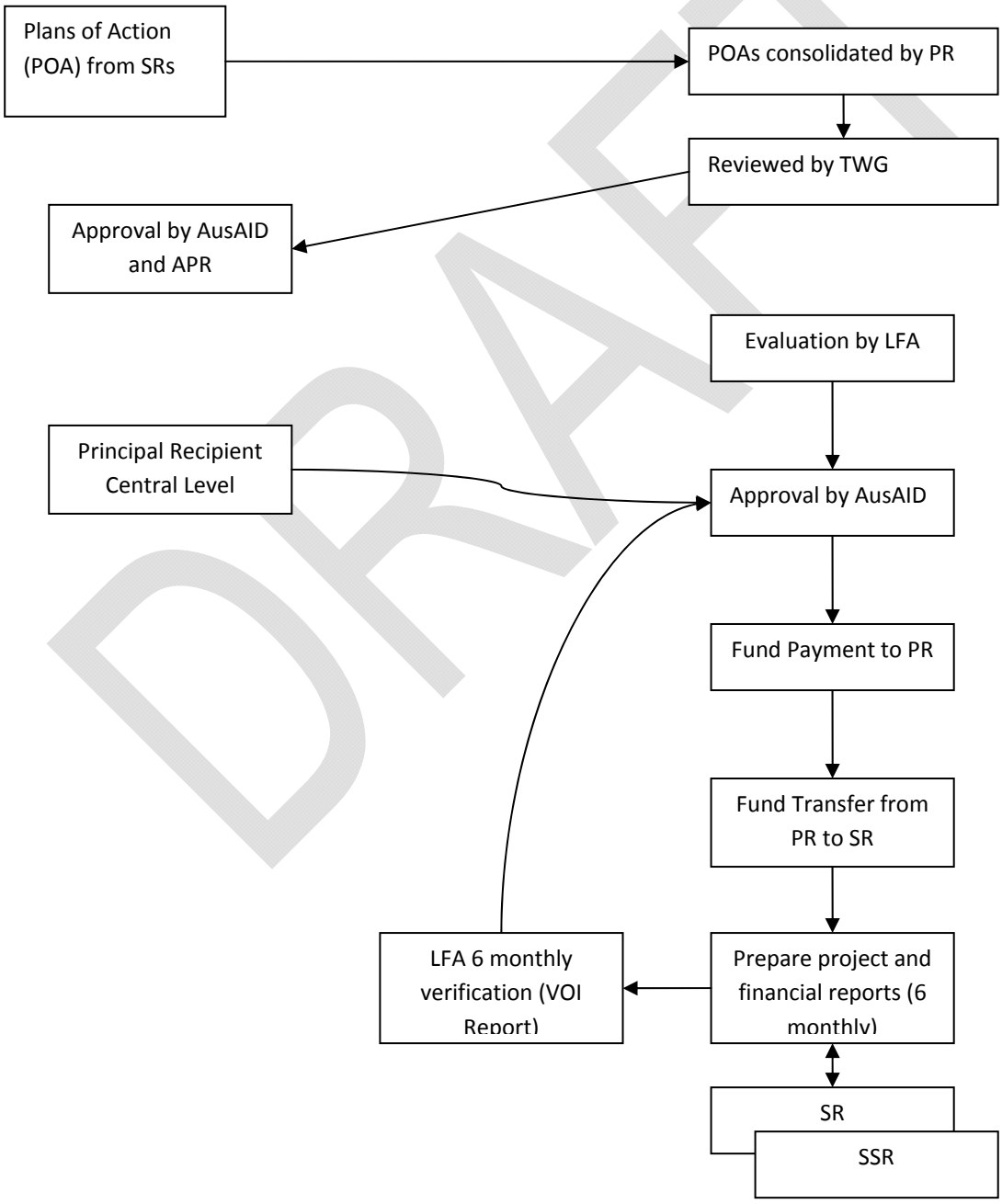
Attachment 3 – Funds Disbursement Mechanism

AusAID would provide a direct cash grant to the Ministry of Health to implement the program, based on the process outlined in the following diagram. Once Plans of Action (POA) have been received from sub-recipients, consolidated, reviewed and approved AusAID will transfer payment (on a bi-annual 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 sub-recipients, which must be accounted for six-monthly and verified by the Local Funds Agent, before AusAID transfers the next tranche.



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Attachment 4 – Excerpt from the 2010 Kemkes Global Fund Project Implementation Manual[91]

C. Salary and Incentive

The GF-ATM grant management, both public service employee and civilians, will be granted salary/incentive. For public service employee attached to his structural position (ex officio), incentive is given based on the mutual agreement between the Ministry of Health and GF-ATM. The incentive structure is as followed:

No	Position	Incentive/Person (Rp)
1	Principal Recipient	17,000,000
2	Authorized Principal Recipient	15,000,000
3	Management Advisor	10,000,000
4	IMCT	5,000,000
5	Project Manager	11,000,000
6	Program Implementing Coordinator (PIC)	8,000,000

Full time public service employee and civilian working for the GF-ATM grant management are paid a salary according to the salary standard agreed by the Ministry of Health and GF-ATM, based on the education and expertise, experience, work load and fund availability, and is determined by the Director General for DC&EH Decree as the Chief of PR. The salary structure is as followed:

No	Position	Salary/Person(Rp)
1	Technical Advisor	17,000,000 – 22,000,000
2	PMU Coordinator	15,000,000 – 20,000,000
3	Deputy PMU	14,000,000 – 16,000,000
4	Admin Coordinator	9,500,000 – 11,000,000
5	Secretary PR	7,000,000 – 9,000,000
6	Project Administration Senior	6,000,000 – 8,000,000
7	Project Administration Junior	3,000,000 – 5,000,000
8	Project Admin Technician	4,000,000 – 6,000,000
9	Driver	1,500,000 – 2,500,000
10	Office Boy	1,000,000 – 1,500,000
11	HRD Coordinator	9,500,000 – 11,000,000
12	Senior HRD	6,000,000 – 8,000,000
13	Recruitment Staff (HRD Staf)	3,000,000 – 5,000,000
14	Training/Data Maintenance (HRD Staf)	3,000,000 – 5,000,000
15	Financial Coordinator	9,500,000 – 11,000,000
16	Financial Controller	7,500,000 – 9,000,000
17	Financial Administrator	6,000,000 – 8,000,000
18	Cashier	3,000,000 – 5,000,000
19	Logistic Coordinator	9,500,000 – 11,000,000
20	Procurement Staff	3,000,000 – 6,000,000
21	Distribution Staff	3,000,000 – 6,000,000
22	Warehouse Staff	3,000,000 – 6,000,000
23	PME Coordinator	9,500,000 – 11,000,000
24	Data Analyst	7,000,000 – 9,000,000
25	Senior Planner	7,000,000 – 9,000,000
26	Junior Planner	5,000,000 – 7,000,000
27	M&E Staf (SR/Partnership)	5,000,000 – 7,000,000
28	Data Collector	3,000,000 – 5,000,000

[91] Payment of incentives is currently under discussion with the Global Fund.

Attachment 5: Terms of Reference for Program Technical Advisor

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 sub-sectors in Indonesia is well targeted to assist Indonesia 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 in Health Systems Strengthening (HSS) program has sprung out of a need to improve some of the systems challenges hindering the delivery of better Primary Health Care for the poor in order to maximise their impact and meet the challenge of achieving the MDGs

The HSS program will be delivered through two forms of aid. Firstly grant funding to the national Ministry of Health for implementation of national and district activities. Secondly through an Implementing Service Provider 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, 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.

Roles and Responsibilities

AusAID is seeking to engage an experienced and highly motivated person to fill the role of Health System Strengthening Program Technical Advisor. The Program Technical Advisor will be responsible for providing technical advice in the planning and implementation of the HSS program so that it contributes to implementation of Government of Indonesia health workforce and health financing policy and decentralised planning..

In doing so the PTA will provide inputs to the Ministry of Health PMO Program manager.

The PTA will report directly to AusAID and the Program Management Office (PMO)

Program Manager located in the Ministry of Health.

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The Advisor will be directly contracted by AusAID through a trusted hiring company and will be located in with the HSS Program Management Unit in the MOH, Jakarta. Key characteristics that will be built into the job description for this role are:

- Expertise in health policy, particularly in Health System 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; and
- Annual 360° performance assessment administered by AusAID.

The program will require consistent, high-level technical inputs and liaison between MoH counterparts in several technical divisions, universities, civil society and development partners to promote effective PHC policy and implementation. It is necessary that the AusAID Advisor present a clear and consistent position on PHC 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. 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 MOH for funding commitment and the 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 activities delivered by the ISP and PMO are consistent and mutually reinforcing
- support the Program Manager to prepare six-monthly reporting to the Technical Working Group and Steering Committee
- through the Program Manager, assist sub-recipients of program grants to develop Plans of Action
- ensure Plans of Action are aligned with Ministry of Health's priorities and consistent with international best practice
- provide technical advice in international best practice on health system strengthening to the Ministry of Health
- assist and mentor staff from the Ministry of Health identify ways to improve their health systems

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- analysing and reporting on key strategic issues relevant to the program and their implications for Australia's support for the health sector in Indonesia
- staying abreast of latest international thinking on development assistance in the health sector and integrating this into programming where appropriate.

It is acknowledged that no individual Technical advisor has the capacity to address all the technical issues that are likely to arise from the Program Focal Areas and the HSS. Therefore, the Advisor will need to be empowered to commission HSS Programming Support directly from the ISP. All HSS Programming Support will need to be separately identified and reported in Quarterly reporting, with the Adviser and Program Manager providing the oversight and performance reporting on these inputs to the Program.

Through the Advisor, AusAID will be present at all decision-making with GOI and stakeholders to ensure policy consistency and a suitable level of representation with those stakeholders. This is especially important where the scope of the Program should change, or resourcing needs to be increased where implementation is accelerated.

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Annex 8: Budget Outline

This annex summarises the outline budget for the Indonesia AusAID Health Systems Strengthening Program. This budget is not binding. The first task of the appointed National Program Manager will be to develop a full 1st year budget using this framework but based on more comprehensive costing of activities with Ministry of Health, Provinces, Districts and Puskesmas.

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

Basic Principles

The key principles for the budget are:

1. Provincial, district and puskesmas level activities should constitute a minimum of 60% of the total budget because these are the activities most critical to achieving the program outcome;
2. Monitoring and Evaluation should be approximately 6% of the total budget;
3. Program management costs should be less than 5% of the sub-total of all activities budget to be consistent with the Global Fund.

Key Budget Headlines

The outline budget is in the table below. The total estimated budget is $49,415,000. Of this 61% ($29.9 million) would be for provincial, district and health facilities to support systems strengthening and service delivery. A further 9% ($4.3 million) would be for MOH policy work, systems strengthening, and research and 4% ($2 million) would be for Poltekkes upgrading.

9% ($4.3 million) would be for technical assistance and operating costs for an ISP and a further 4% ($2.1 million) would be for Health Policy Network and Civil Society work which would be managed by the ISP, at least for first 3 years. 6% ($2.8 million) would be for monitoring and evaluation (of which approx. $1m for an M and E adviser to be managed by ISP).

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

The expenditure profile would start relatively low in the first year and peak in FY 2014-15.

It is expected that $40.05 would be managed through national PMU, and up to $7.4 through the ISP, and the remainder covering the costs of the Senior Adviser and the LFA. The LFA budget, 1% of the total, covers financial management oversight, performance oversight, audits etc.

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Budget Assumptions

The key assumptions behind this budget are:

1. Expenditure in FY 2010-11 will be relatively low because of start-up time and work load.
2. Expenditure in FY 2015-16 in provinces and districts is budgeted at 80% of the previous FY. This is because programs do not stop on the final end date but wind down activities through their last 6 months.
3. Expenditure on other line items for FY 2015-16 are also expected to be lower than previous FY.
4. The Output 2 and Output 3 budget line includes all provincial, district and health facility level activities. 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.
5. Average unit cost for Provinces and District activities draw on AIPMNH experience and are based on the following:
    a. Province allocation: $600,000 for first year of activities and $900,000 for subsequent years;
    b. District allocation: $100,000 for first year of activities and $300,000 for subsequent years.
    c. FY 2011-12 – flat overall rate during set up of $1million for provinces and districts
    d. FY 2012-13 – 2 provinces and 8 districts (plus additional $1 million for preparing second phase of provinces and districts to start)
    e. FY 2013-14 through to program end – 5 provinces and 20 districts
6. 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.
7. Output 5 is expected to be managed by the ISP at least for the first 3 years of the program.
8. Output 1 costs include resources for MOH to contract technical assistance, to fund studies and research, and to develop new systems as per agreed activity list and workplan.
9. Management (including national, provincial and district) costs includes the costs of the PMU in MOH, other salary incentives, management and administration costs in provinces and districts (though probably not sufficient).
10. Monitoring and Evaluation costs could include both funding through PMU, as well as technical assistance from the ISP.
11. ISP TA and management costs includes its core management costs as well as technical assistance to support all program activities. It does not include costs for Output 5.
12. No contingency has been built in. A contingency should be included.

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Indonesia Australia Health Systems Strengthening Program Indicative Budget

	FY 2011-12	2012-13	2013-14	2014-15	2015-16	Total	%
Output 1	$ 500,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 800,000	$ 4,300,000	9%
Output 2 and 3	$ 500,000	$ 3,000,000	$ 8,000,000	$ 10,000,000	$ 8,400,000	$ 29,900,000	60%
Output 4	$ 100,000	$ 500,000	$ 500,000	$ 500,000	$ 400,000	$ 2,000,000	4%
Output 5	$ 200,000	$ 500,000	$ 500,000	$ 500,000	$ 400,000	$ 2,100,000	4%
M and E	$ 500,000	$ 500,000	$ 600,000	$ 600,000	$ 600,000	$ 2,800,000	6%
Sub Total Outputs and M&E	**$ 1,800,000**	**$ 5,500,000**	**$ 10,600,000**	**$ 12,600,000**	**$ 10,600,000**	**$ 41,100,000**	**83%**
Management (includes national, provincial, district)	$ 90,000	$ 275,000	$ 530,000	$ 630,000	$ 530,000	$ 2,055,000	4%
ISP TA and Management	$ 500,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 800,000	$ 4,300,000	9%
Senior Adviser	$ 300,000	$ 300,000	$ 300,000	$ 300,000	$ 300,000	$ 1,500,000	3%
LFA Costs	$ 100,000	$ 80,000	$ 80,000	$ 100,000	$ 100,000	$ 460,000	1%
Sub Total TA and Management	**$ 990,000**	**$ 1,655,000**	**$ 1,910,000**	**$ 2,030,000**	**$ 1,730,000**	**$ 8,315,000**	**17%**
Grand Total	**$ 2,790,000**	**$ 7,155,000**	**$ 12,510,000**	**$ 14,630,000**	**$ 12,330,000**	**$ 49,415,000**	**100%**
	6%	14%	25%	30%	25%	100%	

Note: % column does not necessarily add up to 100% because of rounding on each budget line.

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Annex 9: Theory of Change and Monitoring and Evaluation

Introduction

This annex summarises the Theory of Change and Monitoring and Evaluation Framework for the Indonesia AusAID Health Systems Strengthening Program. It includes:

5. Problem Analysis – why do poor people suffer poor health in Indonesia?
6. Theory of Change
7. Monitoring and Evaluation Framework: The Logical Framework
8. Key points for program inception: Monitoring and Evaluation

A point on terminology in this and other program documents and annexes for the Indonesia Australia Health Systems Strengthening 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 outcome is the next level of achievement that the outputs contribute to the achievement of. The goal is the longer term vision, linking to the Millennium Development Goals, which will be measurable after the life of the program.

1. Problem Analysis – why do poor people suffer poor health in Indonesia?

There are multiple factors behind why poor and near poor people are not benefiting from good health in Indonesia (see Annex 1 and 2 which analyse the available Indonesian data). The high level factors include lack of use of health care, and in particular primary health care, the factor that this program intends to address. Other factors that impact negatively on the health of poor people includes poor access to safe water and sanitation, low employment and income, limited nutrition and diet, low levels of education and in particular female education, lack of access to broader social assistance.

Analysis of health service utilisation in Indonesia (outlined in more detail in Annex 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: (i) lack of health workers in primary health care facilities; (i) cost of health care discourages use by the poor and near poor; (iii) low quality of health workforce; (iv) low quality of health care; (v) perceptions of low quality of health care; (vi) geographical inaccessibility of health care facilities; (vii) lack of consistent availability

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of affordable quality drugs and medicines; (viii) weak health information systems; (ix) policies that are not sufficiently pro-poor and (x) incomplete policy implementation

The problem analyses presented in Figure 1 (next page) focus mostly on health workforce, health financing, and insufficient decentralised planning, budgeting and supervision capacity. There is considerable analysis and evidence suggesting 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% 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 funding for HSS granted in 2008 is currently being reprogrammed. Other development partners including the World Bank, Asian Development Bank and WHO support GOI, in particular on evidence for policy development.

This program has been designed to address some but not all of the above factors, primarily (i) – (v) and (ix) – (x). Figure 1 (on the next page) presents a more detailed problem analysis of the key problems that contribute to poor people not accessing sufficient quality primary health care. Figure 2 (on the next page but 1) 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 themselves 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 increase utilisation.[92]

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

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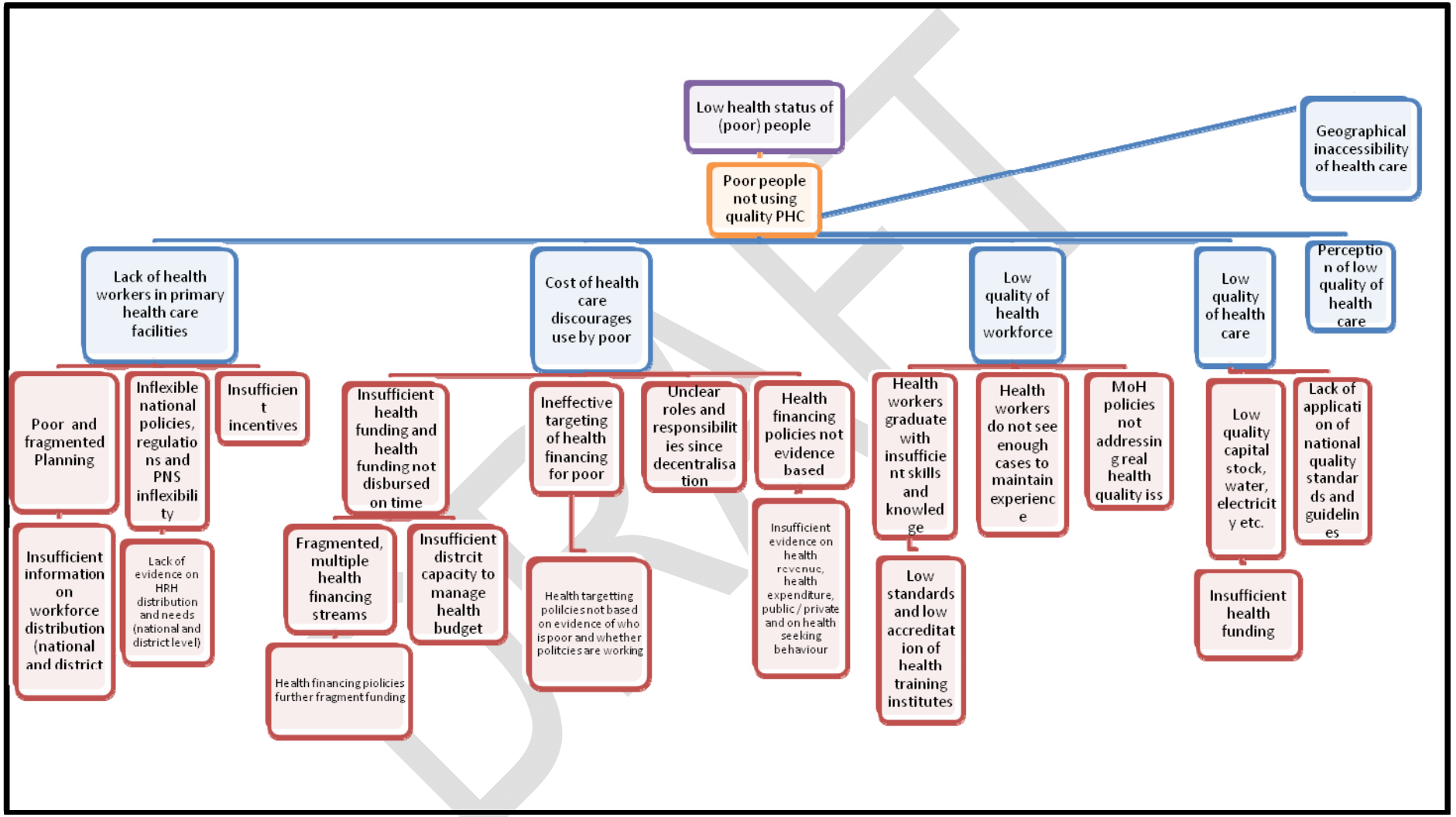
Figure 1: Low health status of the poorest in Indonesia – problem identification and analysis



The boxes indicated in red are those that are the primary focus of this Indonesia Australia Health Systems Strengthening Program.

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Figure 2: Pro-poor health policy – problem identification and analysis

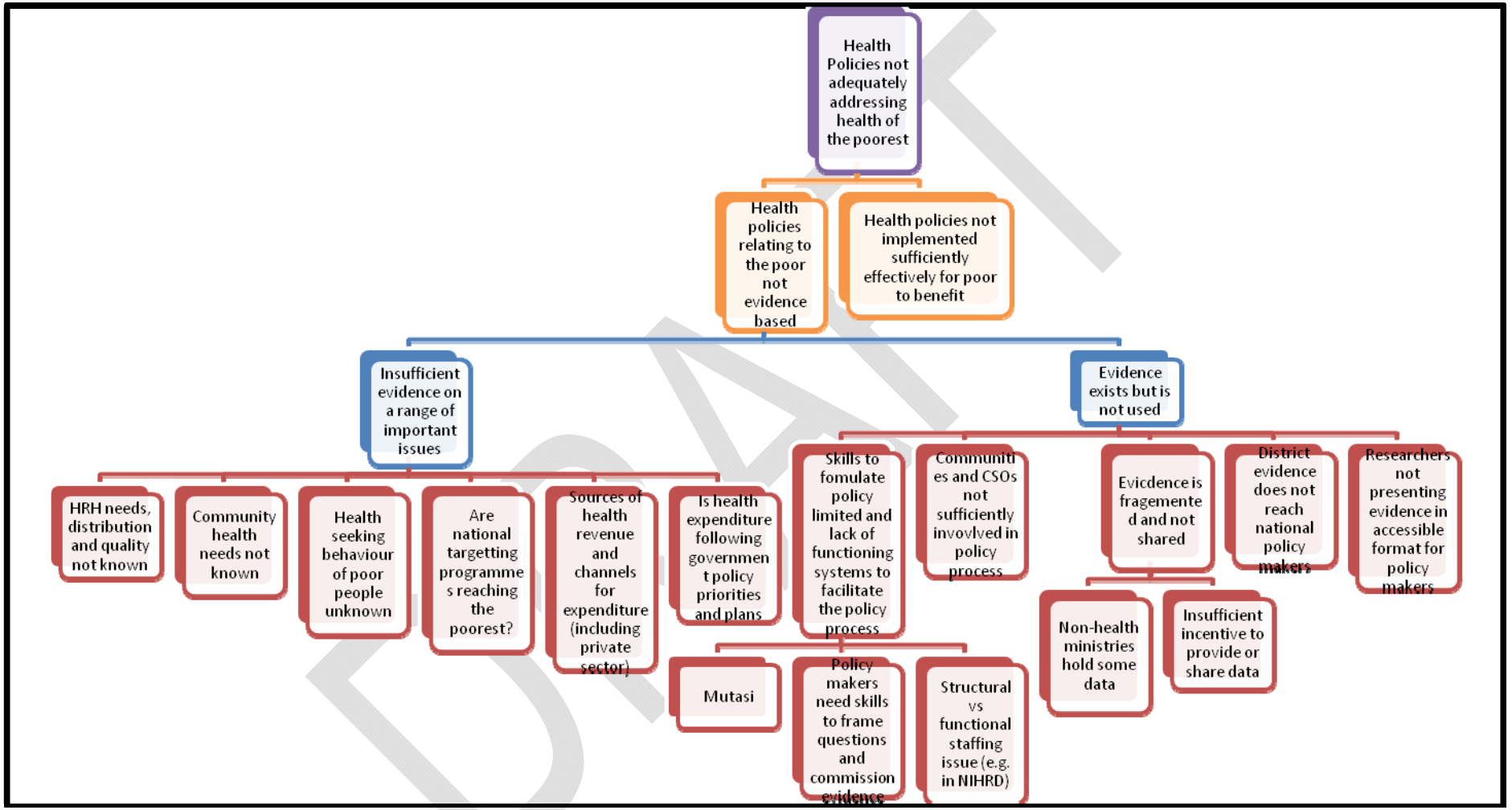

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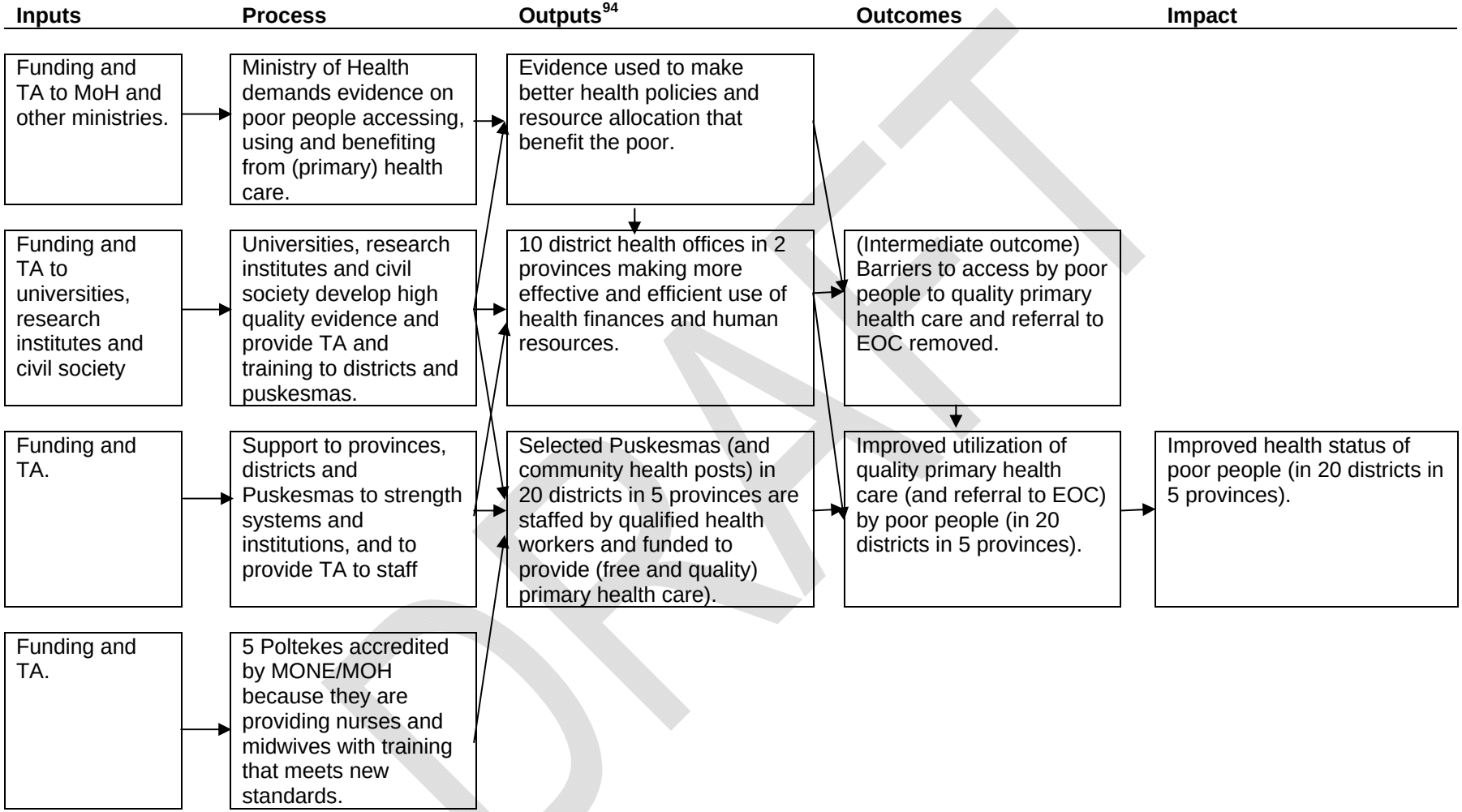
Figure 3: Theory of Change Indonesia Australia Health Systems Strengthening Partnership[93]



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

[94] 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.

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2. Theory of Change

The Theory of Change is outlined in Figure 3. This 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 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 research and technical assistance function of universities and civil society; and the accreditation of nursing and midwifery polytechnics (Poltekkes).

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

Program activities have been developed using experience of the AIPMNH, a workshop with Ministry of Health Officials and 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 contributes to the stated outputs.

Output 1

Achievement of output 1 requires the Ministry of Health to build stronger capacity to (i) identify data needs; (ii) commission research to provide needed data; (iii) analytical skills to use data in development of new policies and iv) effectively disseminating results so 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 identifying and commissioning data, financial support for research and data generation, 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 on-going mentoring and coaching.

Output 2

Achievement of output 2 requires provincial and district health offices to build stronger capacity to (i) plan for more effective use of financial and human resources to deliver primary health care; (ii) develop and monitor results frameworks which capture benefit to poor and near poor; (iii) 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

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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/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 population, monitoring 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 to have developed increased capacity to deliver quality training programs which meet new higher government level accreditation standards. The proposed indicators measure the outcome that would be expected if Polytechnics have developed capacity and met new accreditation standards. The inputs and activities that will be required include technical assistance to Ministry of Health to upgrade curriculum and teaching methods and support Polytechnics to assess their needs and build capacity, technical assistance to polytechnic 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 (i) conduct research on the health of poor people, (ii) make evidence and research accessible to health policy makers, (iii) to 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 also 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 these 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 which use modern adult learning techniques. Financial support will include for these activities, and for civil society to (i) generate demand for evidence based policies and services, (ii) play a role in advocacy and accountability for expenditure at primary health care facilities and (iii) conducting research for health advocacy.

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

a) 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 which will inevitably occur;
b) Systems to mitigate the turnover of staff in district health offices and provincial health offices (and Puskesmas) are set up and functioning;
c) Districts develop the management capacity and incentives to deliver services consistent with MOH priorities and HSSP;
d) Quality of health services – including skills and motivation of staff, availability of the right medicines, supplies and equipment is sustained.

2.2 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 achievement of the overall outcome. The output weighting, the % of total contribution of all outputs to achieve outcome, of outputs 2 and 3 is collectively estimated at 70% with output 1 at 15%, output 4 and 5 at 7.5%.

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

a) GOI continues to increase funding for health care, in particular for the poor (*Jamkesmas*) for MNH (*Jampersal*) and for service delivery (BOK);
b) Improvement in quality and accessibility of primary health care services is recognised by poor people, reducing barriers and increasing demand;
c) Improvements to systems and process in District Health Offices leads to improved resource allocation, and more effective and timely disbursement of health resources;
d) Other programs on decentralisation result in planning, budgeting, approval and disbursement cycle working more quickly to enable disbursement of health funds from national level to begin in Q1 of each year;
e) Support to civil society can increase demand of poor people for health care by increasing awareness of their entitlements from government funding schemes;
f) TA, reforms to systems and oversight are sufficient to ensure that health funding is used for the intended purposes;
g) GOI continues to implement other measures to improve health including improved nutrition, education (particularly of girls), clean water and sanitation.

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3. Monitoring and Evaluation Framework: The Logical Framework

This framework outlines the key elements in the logical framework.

PROGRAM NAME	Indonesia - AusAID Health Systems Strengthening Partnership	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 Health Survey (IDHS/SDKI)	National data will not measure program. IDHS conducted approximately every 3 years but reliant on donor funding.
	Impact Indicator 2		
	1. Under 5 mortality decreased from 44 per 1,000 live births (2007) to 32 (2014 target).	Indonesia Demographic Health Survey (IDHS/SDKI)	National data will not measure program. IDHS conducted approximately every 3 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% SES	Data could be collected and reported in National Socio-economic Survey (Sussenas) 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% SES).	Administered data sets with *Sussenas* providing SES data.	AIPMNH modified

	Outcome Indicator 3		
	1. X% increase in completion of ANC and PNC amongst lowest 40% SES; or gap in coverage of ANC and PNC[95] between rich and poor districts reduced.	Data already reported nationally? May not be disaggregated by quintile and need to use *Sussenas* or other survey.	Standard global indicators modified as per AIPMNH
	Outcome Indicator 4		
	1. Number of primary health care visits per 10,000 population per year (lowest 40% SES) in 20 districts in 5 provinces.	Routine health facility reporting system; maybe need *Sussenas* 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**		
Ministry of Health using evidence-based data and up to date information for the national level policies' decision making on health financing and health human resources to improve access and 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; OR	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 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		

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

	1. Improved HRH information system providing data to support national, provincial and district management	MOH and program records on sources and use of data on HRH	
OUTPUT 2	**Output Indicator 2.1**		
Twenty districts/city health offices in five provinces implement health financing and human health resources' policies and programs more effectively and efficiently to improve access and quality to 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 poor and near poor people.	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 PHO / DHO budget and expenditure data from national, provincial and district levels. Possibly supplemented by DHA, NHA.	Indicator to track whether health expenditure is improving, indicating improved capacity on disbursing and utilising funds. – also acts as a proxy for district level capacity development.
	Output Indicator 2.3		
	1. Number of primary health care facilities with minimum midwives and nurses to provide core services in line with district plan.		Indicator(s) on effective district planning of HRH – also acts as a proxy for district level capacity development.
	2. % of staff in district with agreed job description who receive annual performance appraisal.		
	3. % of staff in post when they should be.		
OUTPUT 3	**Output Indicator 3.1**		
Selected primary health centres (Puskesmas) and village health posts (Poskesdes) in twenty	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 *riskesdas.*	Measure increased affordability. Option 1 is PHC focused, option 2 is whether public funding is benefiting poor people.
	Output Indicator 3.2		

districts/cities in five provinces having(empowered) qualified health workers and have sufficient resources to deliver quality and free primary health care services and referral for the poor and the near poor (Puskesmas to Poned).	3. 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		
	1. Proportion of Puskesmas budget from all national and district sources disbursed to puskesmas each month or quarter	DHA, NHA, routine records, Public expenditure tracking survey	Indicator to measure impact of improved capacity on financial management.
	Output Indicator 3.4		
	1. Distribution of health workers matches planned allocation for primary health care facilities based on occupation/speciality, geographical, demographics.	District records? Survey	Indicator to measure impact of improved capacity on health workforce management.
OUTPUT 4	**Output Indicator 4.1**		
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.	1. 5 Poltekes successfully accredited by 2016	MOH, MONE and Poltekes records	
	Output Indicator 4.2		
	1. Annual number of midwife and nursing graduates per 100,000 populations from 5 Poltekes under new accredited courses.	Poltekes records. Other?	Modified from WHO HSS indicator.
	Output Indicator 4.3		
	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	1. Number of studies and policy relevant publications which can show use of the evidence in policy decision-making.	Program records	

institutes, civil society organizations are able to deliver evidence-based data and advocate the central and local policy-makers on health financing and health workforce and provide TA and training to districts and Puskesmas to increase health access for the poor and the near poor people.	**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.	Program records	

Indicators in this framework are drawn from a number of sources including (i) discussions with Ministry of Health, (ii) WHO publication on 'Monitoring the Building Blocks of Health Systems: A handbook of indicators and their measurement strategies', and (iii) 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.

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4. Key points for program inception: Monitoring and Evaluation

4.1 Data sources

This Indonesia Australian Health Systems Strengthening Program will allocate 6% of resources for 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 logframe. 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.[96] These were assessed as "present but not adequate". Particular weaknesses were identified as the resources available and data management, the latter assessed as "not present at all".

Attachment 1 below includes a summary of existing data sources that have been identified as important for program monitoring, what they 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 socio-economic status. These include the Indonesia Demographic and Health Survey, Primary Health research (Riskesdas), National Socio-economic Survey (Susenas), the Indonesia Health Profile, Programmatic Reporting and Jamkesmas and Jampersal reporting.

4.2 Baseline data

The AIHSSP inception period 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 develop data collection methodologies for example developing consistency between the Riskesdas and Sussenas so socio-economic profile data can be linked to health behaviours and outcomes. This will include staff from the national statistics agency (BPS).

4.3 Potential evaluation questions

This AIHSSP program will support a range of interventions to improve the health of poor people in Indonesia. There will be on-going feedback within the program to enable 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 these can be replicated in other districts and provinces. It is too soon to identify the most valuable evaluation questions to learn but the key evaluation questions could include:

1. Comparison between program counties and non-program counties to measure and evaluate capacity development and achievement of outputs and outcomes;
2. Evaluation of achievement of improve maternal and neonatal health outcomes to understand key factors which contributed;
3. Evaluation of policy initiatives to improve the distribution and presence at work place of health workers; and

[96] http://www.who.int/healthmetrics/library/countries/HMN_IDN_Assess_Draft_2007_08_en.pdf

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4. Evaluation of policy initiatives to improve the planning, disbursement and utilisation of health funding and whether they are achieving their stated health policy objectives, and if so or not, why?

4.4 Monitoring and Evaluation expertise

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

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Attachment: Existing Data Sources to support monitoring and evaluation

1. Indonesian Demographic and Health Survey (IDHS)/SDKI – every 3 years (last survey: 2007)

2007 Indonesia Demographic and Health Survey (IDHS) is a community based survey carried out by Biro of Statistics Indonesia (Badan Pusat Statistik—BPS). The 2007 IDHS is the sixth survey conducted in Indonesia under the auspices of the DHS 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 age 15 to 49 years and currently married men age 15-54 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 will be helpful to policymakers 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 every married women which will provide more accurate statistics on womens health issues.

Source of fund for IDHS

- GoI: supported local costs of the survey.
- United Nations Population Fund (UNFPA) provided funds for questionnaires printing
- and shipment.
- Macro International, Inc (Macro) provided limited technical assistance under the auspices f the Demographic and Health Surveys (MEASURE DHS) program, which is supported by the U.S. Agency for International Development (USAID).
- Other donors provide additional funds to allow other sampling in particular districts and provinces

2. Primary Health Research (Riskesdas) – every 3 years (last survey: 2007, 2010 was comprehensive only intended for MDGs)

Riskesdas is a community based research with the samples taken from household and household's member which were selected proportionate to size of the district/city level. 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 National Socio Economic Survey (Susenas). Riskesdas uses a descriptive cross sectional survey. Riskesdas 2007 covers bigger samples than previous health surveys attached to Sussenas, and covers wider health aspects and using samples from 258,366 household and 987,205 household

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members and measuring many public health indicators e.g. under five nutritional status; .

Weaknesses:

(1) It does not cover data from newly established districts
(2) Household absence
(3) Different time in collecting data
(4) Estimation at district level which is not valid for all indicators
(5) Biomedical data which only represents urban block census
(6) Currently unable to link up with Sussenas data on socio-economic status of respondents although this is being addressed.

The last complete Riskesdas survey was conducted in 2007 although in 2010 MoH conducted another Riskesdas but it was only covering the MDGs indicators.

3. National Socioeconomic Survey (Susenas) 2007 – every year (last survey: 2010)

Indonesia Social and Economic Survey (Susenas) is a nationwide survey conducted by the National Bureau of Statistics - BPS to collect information on social and economics indices. It serves as a main source of monitoring the social and economic progress in the society. Susenas was conducted on an annual basis. It assess detailed information on basic social and economics issues. The survey covers basic information of household and individual characteristics on health, death, education/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 district/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. 2010 survey results now available.**

4. Indonesia Health Profile – every year (2010 is last health profile)

Produced annually by Ministry of Health (Centre for Data and Information/Pusdatin). Last health profile is in 2010.

Source of data: from facility based data to Provincial/District Health Office to Central Office (Pusdatin)

Data consists of the following:

1) Profile of health situation in each district/provinces: mortality, morbidity, nutrition
2) Profile of health services in each district/provinces: primary health care; referral services; communicable and non-communicable diseases; nutrition status
3) Health workforce: function and responsibility of health workforce; number of health workforce and financing of health workforce in each district/provinces

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Type of data: raw data and analysed by Pusdatin and technical units within MoH

Weaknesses: (1) Not all data are up to date and reliable

(2) Facilities and district/provincial health office still reluctant to provide data to Pusdatin due to local regulation law

(3) Lack of coordination between Pusdatin and other technical units

(4) Limited capacity within Pusdatin to compile and analysis the data

(5) Due to decentralization, not all district/cities provides reports to Pusdatin

6. Programmatic Reporting

Timeline: facilities provide quarter report to DHO then DHO reports to PHO and then to Central program specific. E.g. Health Workforce Unit, Maternal and Child Health Unit, etc.

Flow of reporting

PKM through facilities health information system (SIMPUS) → provides two weekly reports to District Health Office (DHO) *hard copy* -→ forward to Provincial Health Office (PHO) *hard copy/ soft copy* → PHO recap the data then submit to Directorate of Primary Health Care, MoH/Central level at the end of every month – *email*.

Weaknesses:

(i) Delay in the submission of the report from facilities automatically will impact the reporting from PHO to central level
(ii) There is no obligation for sub national office to submit data to central level so central level MoH does not always receive the report regularly. However, this has improved in the last two years as there is a MoH policy on the matter
(iii) Issues with geographically location and infrastructure

7. 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 cc-ed district and provincial health office (www.ppjk-depkes.go.id). To date, the compliance rate is still low. In areas where facilities are unable to access internet, they provide data of utilization of Jamkesmas through excel spreadsheet.

Hospital provides monthly data through a web based application directly to PPJK and cc-ed district/provincial health office.

The report consists of:

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- utilization rate of Jamkesmas,
- claim rate, and
- disease pattern.

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

Jampersal

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

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Annex 10: Program Implementation Schedule

Program implementation will begin in 2011 and continue until June 2016. This program implementation schedule is based on an assumption that the HSS Program will be formally approved by AusAID and the Ministry of Health in August- September 2011. The schedule is outlined by quarter according to Australian Financial Years with an end date of 30 June 2016.

It is anticipated that the Program Management Office and Implementing Service Provider will become operational in early 2012. In the time between program approval and the PMO and ISP becoming operational it will be important to maintain the momentum that has been built up between Ministry of Health and AusAID with an inception phase that will prepare for implementation.

Key inception phase activities could include:

- Fiduciary risk assessment
- Negotiating grant agreement with MOH and establishment of PMO with recruitment of staff
- Tender for ISP
- Agreement on logical framework including targets, baselines and milestones
- Preparation for baseline data collection and analysis
- Program introduction to provincial and district authorities
- Capacity assessment in initial provinces and districts on key HRH and financial issues

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Program Implementation Schedule

	By whom	2011	FY 2011-2012				FY 2012-2013				FY 2013-2014				FY 2014-15				FY 2015-16			
		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 PMO	AusAID																					
Signature of grant agreement with MOH and establish PMO	MOH																					
Recruit PMO 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	PMO																					
Steering Group meeting	MOH / PMO																					
Annual Workplan approved	SC / PMO /ISP																					
Implementation of workplans	PMO / ISP																					
Evaluability Assessment undertaken and M and E Plan developed	PMO / ISP																					
Gender Plan developed	PMO / ISP																					
Develop Policy Communications Plan	PMO / ISP																					
Provincial Offices established	PMO																					
District offices established	PMO																					
Financial Management training	PMO / ISP?																					
Develop Financial Management Plan	PMO / ISP																					
Baseline data gathered	PMO / ISP																					
Endline surveys	PMO / ISP																					

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Annex 11: Draft Position Descriptions and Terms of Reference

This annex includes three draft documents:

1. Draft Terms of Reference for the Implementing Service Provider
2. Draft Terms of Reference for the Program Technical Advisor
3. Draft Terms of Reference for the Monitoring and Evaluation Advisor

Attachment 1:

Australia Indonesia Health Systems Strengthening Program

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 sub-sectors in Indonesia is well targeted to assist Indonesia 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 Health Systems Strengthening (AIHSS) program has sprung out of a need to improve some of the systems challenges hindering the delivery of better Primary Health Care for the poor in order to maximise their impact and 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 5 provinces). The AIHSS program will be implemented for 5 years from 2011 to 2016 with a total budget of $50 million.

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The AIHSS program will be partially harmonised with a Global Fund HSS grant of $37 million over 5 years.

The HSS program will be delivered through two forms of aid. Firstly grant funding to the national Ministry of Health for implementation of national and district activities, to be managed by a Program Management Office in the Ministry of Health. Secondly, technical assistance and capacity building will be provided by an Implementing Service Provider 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, 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 Implementing Service Provider will be responsible for the following deliverables:

1. Provide technical assistance and training to support the Program Management Office in the delivery of its outputs;
2. Develop an annual workplan of technical assistance and training that responds to the needs and demands of the PMO, for approval by the Steering Committee;
3. Provide an annual report to the PMO, Steering Committee and AusAID on ISP performance and activities;
4. Develop a performance framework for monitoring all ISP activities

<u>Health Policy Network</u>

5. Conduct analysis of existing university and research institutes and develop a concept note for the Steering Committee on the scope, purpose, deliverables and activities for a Health Policy Network;
6. Managing a tendering process for Indonesian Universities and Research Institutes to develop a Health Policy Network;

<u>Civil Society Challenge Fund;</u>

7. Develop a concept note for the 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
8. Manage the Civil Society Challenge Fund;

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9. Provide annual reports to the Steering Committee on the Health Policy Network and Civil Society Challenge Fund;

Monitoring and Evaluation

10. Provide technical assistance and training to support the Program Monitoring and Evaluation Adviser;
11. Take over the funding and contracting of the Monitoring and Evaluation adviser from AusAID.

Skills and Competency Required

The Implementing Service Provider will be required to demonstrating the following skills and competencies:

1. Experience in the provision of technical assistance in support of a Government led health systems strengthening programme;
2. Strong Health Systems expertise in particular in the fields of health financing, human resources for health, health planning, budgeting and management at district level in decentralised health care systems;
3. Experience of support health research and health policy analysis
4. Experience of 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.

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Attachment 2:

Australia Indonesia Health Systems Strengthening Program

Terms of Reference for Program Technical Advisor

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.

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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 Health System Strengthening Program Technical Advisor. The Program Technical Advisor will be responsible for providing technical advice in the planning and implementation of the HSS program so that it contributes to implementation of Government of Indonesia health workforce and health financing policy and decentralised planning.

In doing so the PTA will provide inputs to the Ministry of Health PMO Program manager.

The PTA will report directly to the Program Management Office (NPMO)

Program Manager located in the Ministry of Health.

The Advisor will be directly contracted by AusAID and will be located in the HSS Program Management Unit in the MOH, Jakarta. Key characteristics that will be built into the job description for this role are:

- Expertise in health policy, particularly in Health System 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; and
- Annual 360° performance assessment administered by AusAID.

The program will require consistent, high-level technical inputs and liaison between MoH counterparts in several technical divisions, universities, civil society and development partners to promote effective PHC policy and implementation. It is necessary that the AusAID Advisor present a clear and consistent position on PHC 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. This will involve significant periods of time visiting the provinces and districts in which the program will be operating.

Duties will include the following:

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- Assisting the Program Manager in coordination and presentation of the Annual Activity Plan to AusAID and the MOH for funding commitment and the 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
- support the Program Manager in identifying technical assistance and training needs at national, provincial and district level and either (i) support use of PMO funding to commission TA or (ii) liaise with ISP to include TA needs in ISP annual work plan
- work with Program Manager to communicate needs and review annual work plan and performance reports from ISP
- ensure activities delivered by the ISP and PMO are consistent and mutually reinforcing
- support the Program Manager to prepare six-monthly reporting to the Technical Working Group and Steering Committee
- through the Program Manager, assist sub-recipients of program grants to develop Plans of Action
- ensure Plans of Action are aligned with Ministry of Health's priorities and consistent with international best practice
- provide technical advice in international best practice on health system strengthening to the Ministry of Health
- assist and mentor staff from the Ministry of Health identify ways to improve their health systems
- analysing and reporting on key strategic issues relevant to the program and their implications for Australia's support for the health sector in Indonesia
- staying abreast of latest international thinking on development assistance in the health sector and integrating this into programming where appropriate.

It is acknowledged that no individual Technical advisor has the capacity to address all the technical issues that are likely to arise from the Program Focal Areas and the HSS. Therefore, the Advisor will advise the Program Manager when there is a need to commission additional support directly from the ISP. All HSS Programming Support will need to be separately identified and reported in Quarterly reporting, with the Adviser and Program Manager providing the oversight and performance reporting on these inputs to the Program.

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Attachment 3:

AusAID Indonesia program has standard terms of reference for Monitoring and Evaluation Advisers. These will need to be adapted for a government led health systems strengthening program and agreed with the Program Manager of the Program Management Office.

Key Deliverables and Requirements from the Monitoring and Evaluation Adviser for this Australia Indonesia Health Systems Strengthening Program

The Monitoring and Evaluation Adviser will report to the Program Manager of the Program Management Office. (These Terms of Reference will be agreed with the Program Manager).

The M&E adviser will be responsible for:

1. Supporting the Program Management Office (PMO) in finalising the Program Logical Framework including an evaluability assessment, agreement on all indicators, baselines, milestones targets and data sources;
2. Liaise with the Global Fund funded HSS program which has a strong Health Information System component, and ensure there is strong synergy and no duplication with Global Fund supported HIS activities; Consideration should be given to shared indicators between Global Fund, AusAID and GAVI funded HSS initiatives.
3. Support the PMO and MoH to identify all data sources and any capacity issues or additional data sources or surveys required to report on program performance;
4. Lead and support the development of an M and E capacity development plan to ensure that all required data can be generated and analysed
5. Supporting the PMO to commission technical assistance, training and capacity building to strengthen and improve, as required, national surveys or health information systems;
6. Support the PMO 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. Quality assure annual performance reports against the logical framework;
8. Support the generation and analysis of baseline and endline data.

AusAID Indonesia Standard Example TOR for an 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.

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1. Qualifications

The consultant should hold a post graduate 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 which 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 preparation1. 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 breakdown and communicate complex concepts simply with a range of stakeholders in multi-cultural 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

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feasible and value for money, and that the M&E systems meet the needs of all relevant stakeholders.

2.6 Demonstrated on-going 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 (EA) 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 1 for a guide on the scope of an EA).

3.2 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.

3.3 Identify where the implementation team will require on-going 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].

3.4 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.

3.5 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 on-going 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.

3.6 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 1. 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.

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3.7 Prepare relevant information in advance of any review team missions.

3.8 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.

3.9 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].

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Annex 1: Recommended Scope of an Evaluability Assessment

Monitoring and Evaluation Specialists are given a fair degree of freedom to design and conduct the Evaluability Assessment (EA) according to what they consider the most appropriate. The scope of the EA 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 (i.e. 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 longterm and end of program outcomes, and establish an agreed logic model/theory of change for the initiative. Where a logic model/theory of change cannot be developed then a clear rationale is provided, and an action plan proposed for when this 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. 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/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. Clear identification of issues and/or constraints that will affect the design of the M&E plan.

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Annex 12: Risk Analysis and Risk Management

Introduction

This annex summarises the analysis of the key risks to successful implementation of the Indonesia – Australia Health Systems Strengthening 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.

Risk	Probability	Impact	Comments and Risk Management Strategies
General risks			
There are reports of misuse or wastage of Ministry of Health funds.	High	High	• Ring-fencing of AusAID funds to avoid contamination • Identification of a mechanism to deal with allegations of funds misuse with the MOH
Government commitment to financing universal coverage and strengthening health systems is not sustained.	Low	High	• 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	• 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

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Risk	Probability	Impact	Comments and Risk Management Strategies
			society, parliamentarians, media. • Program also supports advocacy of evidence from eg. Different levels of govt, 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	• Capacity building and technical assistance develops systems in the offices, as well as individual skills. • Program operates in sufficient 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 Office (PMO) does not increase national ownership.	Low	High	• AusAID ensures all elements of strategic decision making are conducted jointly. • Clear description of roles and responsibilities of PMO, and its accountability with the MOH are agreed at program outset.
There are reports of misuse of wastage of AusAID or Global Fund HSS funds in Indonesia.	Med	High	• 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

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Risk	Probability	Impact	Comments and Risk Management Strategies
			recover assets if required. • Semi annual Verification of Implementation and annual on-site data verification conducted by the Local Fund Agent • Annual audit by BPK
National level oversight of provinces and districts is weak	Medium	Medium	• Oversight and monitoring arrangements agreed at outset to ensure national involvement. • Program designed to link to national MOH interests and thereby increase stake on program success.
Capacity in district health offices remains weak	Medium	High	• 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 TA	Low	Low	• AusAID contracted Resource Facility provides TA 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	• Program Steering Committee is AusAID specific oversight mechanism providing high level forum for dialogue • AusAID has strong in-country presence and will coordinate with GF including through CCM mechanism
Program leadership of different components is	Low	Medium	• Program Management Team comprising managers of each key component meets monthly

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Risk	Probability	Impact	Comments and Risk Management Strategies
uncoordinated.			with TOR to coordinate. • Program Steering Group TORs include oversight to ensure all program components contributing to the shared outcome.
The absorptive capacity of the PMO (at all levels if they are established) or sub-national HO is limited	Medium	High	• Technical oversight on quality of PMO provided by Program Technical Advisor • PMO staff are employed for PHO and DHO
Changes in the political economy across the sector (across all levels of govt and legislature)	Low-Med	High	• Stronger links between MOH and AusAID delivered through the program enable changes to be anticipated and the program to adapt accordingly • At subnational level alignment with AIPD 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 HSS outcomes - AIPMNH	Low	Med	• The role of Program Technical Adviser (PTA) reduces the risk and ensures that effective activities are selected for implementation. • NPMO will continue to provide significant resources to build capacity for improved data analysis, prioritisation and preparation of medium term strategic and

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Risk	Probability	Impact	Comments and Risk Management Strategies
			investment plans as a basis for annual work plans and selection of activities. • Work plans will be subject to approval by Steering Committee.
The establishment of the PMO (mechanism etc) encounters delays that impact on implementation	Med	High	• Clarity between AusAID and MOH on roles and responsibilities and timelines on recruitment of staff to PMO and early agreement on respective roles in recruitment of PMO staff in districts and provinces • Close coordination between AusAID and MOH during the establishment process
Delays in negotiations and signing of Subsidiary Arrangement and Grant Agreement	Low	High	• SA discussions already commenced in June 2011 with relevant MOH directorates • Continued close coordination between AusAID and MOH during this process
Ineffective use of resources due to a lack of cooperation between MOH, other relevant ministries and subnational government partners.	Med	High	• 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 impact on use of resources • Role of the PTA (eg. As identified in their TOR) will include early identification of cooperation issues that may impact on use of resources. • Role of Technical Working

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Risk	Probability	Impact	Comments and Risk Management Strategies
			Group to ensure consistency between AusAID and GF HSS programs and ensure HSS grants are aligned with MoH priorities
Improvements in PHC services are not recognised by poor people and there is no change to demand	Low	Low	• The HSS program will work in the same five provinces and 20 districts as the AIPD which has a strong focus on generating demand for health services. • Work in VPs office to better target Jamkesmas to lower two income quintiles • PNPM Generasi CCTs to be rolled out nationally from 2012.

It is recommended that the national PMO develops a risk register in the first six months of the program for approval by the program steering group. This risk register will outline the risks, the level of probability, potential impact, and risk management strategies. The risk register should be updated biannually to monitor risks, identify emerging risks, and update risk management strategies. The program steering group might consider identifying owners of each of the risks amongst the steering group to give high level leadership to risk management.

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